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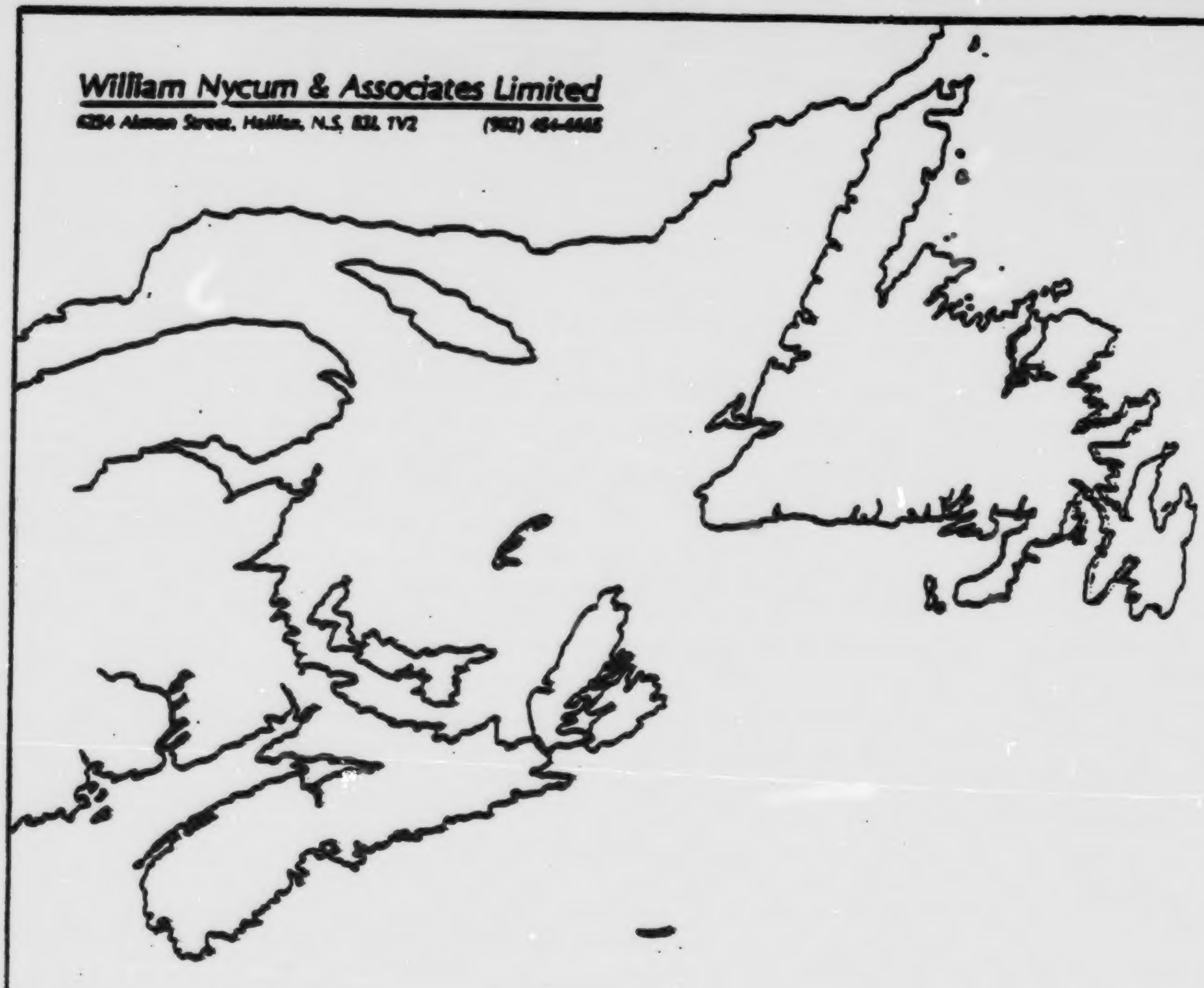

Provincial Bed Study
Executive Summary

Department of Health
Newfoundland and Labrador

DEPARTMENT OF HEALTH
Newfoundland & Labrador

PROVINCIAL BED STUDY

EXECUTIVE SUMMARY

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Acknowledgments

Throughout the study, the Consultants received assistance from many persons. We would like to take this opportunity to acknowledge the time and efforts of all those who helped, but in particular, the following groups.

Our special thanks are extended to the Boards and staff of hospitals and nursing homes for the valuable information they provided and for their assistance in arranging meetings and transportation to some of the more isolated communities in the province.

Public Health Nursing staff and the staff of the District Social Services offices are thanked for their time and effort in completing surveys and also for their invaluable input into the regional meetings. The input received from representatives of the medical community, from voluntary agencies and community groups at these meetings, was also extremely valuable to us, particularly in providing us with insight into local conditions which we would otherwise have been unable to obtain.

We would also like to extend our sincere thanks to the Licensed Boarding Home Operators who so willingly opened their doors to us, often on short notice.

Staff of the Department of Health and other Provincial Government Departments were also very helpful in providing us with important background and statistical information.

Finally, we would like to recognize the many hours spent by members of our Advisory Committee in guiding us throughout the study.

William Nycum & Associates

Chapter 1
INTRODUCTION

At the request of the Department of Health of Newfoundland and Labrador, a detailed study of the requirement for acute and long term care services in Newfoundland and Labrador was conducted between August 1985 and March 1986. The study was undertaken in response to two recommendations of the Royal Commission on Hospital and Nursing Home Costs. They were as follows:

1. That a detailed provincial bed study be conducted by region and hospital to determine:
    (a) in so far as possible, the role and service function of each region and hospital;
    (b) the requirement for general hospital beds up to the year 2000 and;
    (c) the potential for reduction of existing beds to realize some or all of the savings attributable to the closure of 355 beds (or thereabouts, depending on the impact of the new facilities presently being constructed).
2. That plans be developed for the construction of 700 additional nursing home beds.

The study was then expanded to address the requirement for services to meet the needs of those who require primarily supervision, often referred to as Level I services. This aspect of the study was to determine the number, location and priority of additional licensed boarding home beds required in the province.

The Royal Commission recommended that a maximum of 1185 acute care beds be provided in St. John's. Since the allocation of these beds is the subject of a study being conducted by the St. John's Hospital Council, this study does not provide recommended capacities for the hospitals in St. John's. However, the consultants reviewed data from a number of sources and met with personnel from all hospitals in St. John's regarding the Royal Commission's recommendations. In addition, the consultants discussed bed numbers with personnel from hospitals outside St. John's. As a result of our studies, we feel that the 1185 acute care beds recommended for St. John's will be more than adequate to meet the needs until 2001.

Chapter 2
APPROACH

The study was based upon the assumption that regional self sufficiency in health care delivery is a desirable and achievable goal except for tertiary care provided only in St. John's. In the short to medium term, this goal, as it pertains to acute care, may not be completely attainable in some regions and in some specialties. Self sufficiency in the provision of long term care services however, should be attainable in all regions of the province.

The number of acute care beds required in any region of the province is dependent upon the availability of long term care beds. Similarly, the requirements for institutional beds and services, whether for acute care or long term care, is affected by the availability of community based health care and home support services.

In view of this, the consultants based the plans for regional health services on the assumption that a major commitment will be made by the Province to develop comprehensive, community based home care and home support services. The development of comprehensive home care/home support services should reduce the requirement for institutional beds. Therefore, bed numbers recommended are maximum numbers and may be reduced.

The consultants accepted the assessment of the Royal Commission that there was an excess of acute care beds in the province. Based upon a review of information from other provinces and of past and projected trends in hospital utilization in Newfoundland and Labrador, the Commissions' target norm of 3.5 - 4.0 acute care beds per thousand population was considered appropriate by the consultants for use in the study.

From the outset, the intention was to validate the needs for long term care services rather than accept the norms recommended by the Royal Commission. However all of the information required to do a detailed needs assessment was not available. Based on the information available to the Consultants during the course of the study, the norms of 40 beds per thousand population 65 years and over for level II and III care and 30 beds per thousand population 65 years and over for level I care (as recommended by the Royal Commission) were considered not unrealistic.

It should be noted that in some regions of the province, beds required for either acute or long term care may be higher than that recommended through application of the norms.* Factors such as isolation, problems with transportation, etc. were taken into consideration by the consultants in recommending bed numbers.

Following is a summary of the activities undertaken in an attempt to define needs and to support the bed numbers recommended by application of the formulae discussed above:

1. A review of morbidity and mortality data for Newfoundland and Canada.
2. A review of trends in occupancy levels by size of hospital and type of service within hospitals.
3. An analysis and projection of referral patterns.
4. A review of population projections by age category.
5. A review of literature on acute and long term care services from many developed countries including Great Britain, U.S.A., The Netherlands, Denmark and West Germany.
6. A review of recent Canadian studies and reports related to long term care needs and services.
7. Visits to most hospitals and nursing homes in Newfoundland and Labrador during which extensive discussions were held with staff.
8. A review of reports and briefs on long term care needs submitted by various groups in Newfoundland and Labrador.
9. A survey of waiting lists* for all nursing homes in the province.

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* In order to refine the norms, it is essential that the Province of Newfoundland and Labrador develop a comprehensive information base for acute and long term care. For example, utilization information for ambulatory care services similar to that reported for inpatient services is required. Also a source of comprehensive information such as could be generated through regional assessment and placement services (including functional, social and economic information, etc.) on persons requiring long term care would be extremely useful in determining the "need" for specific services.

10. A survey of public health nurses, V.O.N., home care programs (where applicable) and district social services offices.
11. Discussions with government officials and selected voluntary agencies.
12. Meetings held in each long term care district** to which were invited health care providers and consumer groups.
13. Visits to selected boarding homes and other related facilities such as Civic # 4.

In developing recommendations, the consultants also took into consideration anticipated future trends and a number of factors which are expected to have an important impact on the use of institutional beds and services. These included the following:

1. The effect of anticipated changes in technology and improvements in transportation on the pattern of health care delivery.
2. The extent to which attitudes of health professionals and the public are directed towards prevention of institutionalization.
3. The extent to which financial incentives can and should be used to encourage use of the best and least expensive type of service.
4. The extent to which modifications in lifestyle should affect morbidity.

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* Waiting lists do not necessarily accurately reflect those in "need" of nursing home care.

** The only long term care district in which the consultants did not have a regional meeting was in the Northern Region. The meeting scheduled for this district was canceled due to a blizzard. However, lengthy telephone conversations were held with appropriate individuals to discuss requirements for long term care in the district.

Chapter 3
THE CONTINUUM OF CARE

In recent years, the importance of developing resources to meet the needs for chronic and rehabilitative care, as well as for acute care, has gained increasing recognition. The Canadian Medical Association Task Force on the Allocation of Health Care Resources recognized that this continuum of care was a key factor in the provision of effective health care services. The Task Force Report emphasized "that there should be enough flexibility within the system to enable an individual to move freely from one level of care to another, and an assessment service so that the needs of each individual can be periodically evaluated and met".[1]

In order to maximize the effective utilization of institutional beds and services, there must be a range of services along the continuum of care. Some of the services along this continuum need strengthening as discussed below in order to provide a better balance of services in Newfoundland and Labrador.

Home Care/Home Support

The Royal Commission discussed in some detail the weaknesses related to Home Care and Home Support services in Newfoundland and Labrador. Therefore the following is only a brief summary of the consultants' findings which confirm that some of the problems as identified in the Commission Report still exist.

Throughout the province, there are numerous institutions and agencies involved in providing services to individuals in the home. In some areas, there are formalized "home care" programs, while in others, the public health nurses provide nursing services to the extent that resources permit. Some areas have Social Services homemakers working independently of other service providers, while in other areas formalized programs employ Social Services homemakers. In many areas, these homemakers lack adequate training and are not well supervised. Because of the 20 week nature of the program, continuity is a major problem. Nowhere in the province did the Consultants encounter an assessment and placement service which provided access to a full range of services.

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1. Health: A Need for Redirection, C.M.A. Task Force on the Allocation of Health Care Resources, p. 30.

Although the provision of Home Care/Home Support services is generally viewed as a very positive step, some of the existing programs are fragmented, inconsistent, and poorly organized. As a result there is an understandable reluctance on the part of health care providers and those who could benefit from such services, to rely on or take advantage of them.

There is a need to improve the image of Home Care/Home Support services in the province if the trend towards over reliance on institutional care is to be reversed. Government's initiative to coordinate responsibility for these services within the Provincial Departments involved is a very positive first step towards developing the comprehensive, coordinated and consistent services that are required.

Acute Care

As indicated in the Royal Commission report, acute care services are well established in Newfoundland to the extent that there are excess acute care hospital beds in the province. **Further development of alternatives to inpatient services such as traveling clinics and hostels, is required.**

The consultants accepted the assessment of the Royal Commission that there was an excess of acute care beds in the province and adopted the target norm of 3.5 - 4.0 acute care beds per thousand population. The consultants refined this norm to reflect the referral patterns observed in the province, whereby approximately 10% of the hospital care for residents living outside St. John's is received in St. John's hospitals. The extent to which this referral pattern will continue should be evaluated in light of expansion of specialty services in the regions. For planning purposes we have assumed that in the short run, this pattern will continue. Therefore, the norm applied to the regional populations to determine requirements for acute care beds was 3.15 - 3.60 beds per thousand population.

A further refinement resulted in development of the norm of 1.125 beds per thousand population aged 0 - 14 for pediatric beds in designated units. Note that these beds are included in the norm of 3.5 - 4.0 beds per thousand population. (See discussion paper on Pediatrics in main report for rationale.)

The Commission also addressed a number of other major issues to be resolved in rationalizing health care services in Newfoundland. These will not be repeated here. However, the following points from the consultants' review regarding rehabilitation, psychiatry and long term care should be noted.

Rehabilitation

Adult Special Rehabilitation

The only resource for adult special rehabilitation in Newfoundland and Labrador is the Leonard A. Miller Centre in St. John's. This centre operates a 20 bed unit which provides comprehensive, multidisciplinary rehabilitation programs aimed at restoring patients to maximum functioning in the community. The types of persons admitted to this unit include those with spinal cord injuries, brain damaged patients with high recovery potential, amputees and very selected strokes (young, high potential). At this time, there does not appear to be a need to expand these facilities.

General Rehabilitation

General rehabilitation is usually considered to be a slower paced, less "high tech" type of rehabilitation for patients such as stroke victims, those with neurological disorders, elderly amputees, etc. The only facilities for general rehabilitation are the 30 bed "geriatric" unit at the Miller Centre and 8 beds in the Special Care Unit of Western Memorial Hospital in Corner Brook. The 30 bed unit at the Miller Centre serves primarily the Avalon Peninsula and the Western Memorial unit serves primarily the Western region. Therefore the rest of the province has limited access to general rehabilitation services.

All of the hospital personnel interviewed felt that the lack of this type of service had definitely influenced the need and demand for long term care. The need for rehabilitation services will increase further with the increasing percentage of elderly in the population.

The following recommendations are made concerning development of General Rehabilitation beds in Newfoundland:

1. The guideline of 0.2 beds per thousand population should be adopted as a planning tool for general rehabilitation beds.

2. Corner Brook and Gander should be considered as high priority for expansion of general rehabilitation services. Once these units are fully funded, the number of beds at the Miller Centre should be reviewed. The need for an additional 15 - 30 beds should be considered at that time. Also at that time an additional unit should be opened in St. Anthony if feasible.

Pediatric Rehabilitation

A role study undertaken in 1984 by the Children's Rehabilitation Centre in St. John's identified the need to improve pediatric rehabilitation services throughout the province. These services are primarily outpatient and community based services with the Children's Rehabilitation Centre providing the inpatient care and specialty resource requirements.

There is a definite need to expand services in the community to meet the needs of children with disabilities and their families. Development of these services, however, does not affect this bed study, as the only beds providing this type of care are located at the Children's Rehabilitation Centre in St. John's.

Psychiatry

Psychiatric mental health services are acknowledged as being underdeveloped in Newfoundland. Psychiatrists and other mental health personnel are in short supply and programs are minimal, particularly outside St. John's.

There is a need to develop and implement a comprehensive, coordinated system for provision of mental health services to all ages in the province. The distribution of acute and long term beds, including those at the Waterford Hospital should be part of this comprehensive plan.

As regional psychiatric services are developed, it is anticipated that the number of persons requiring referral to the Waterford Hospital will decrease, hence the number of beds required at this facility should decrease. The method of provision (i.e. inpatient vs. outpatient) of psychiatric services in future however, is not as clear as for obstetrical or pediatric services for example. In the absence of a comprehensive plan, the consultants were unable to make recommendations on beds required by region and facility. Therefore, in line with recommendation 4.109 of the Royal Commission Report, no changes in the numbers of psychiatric beds in acute care hospitals have been recommended. Beds for the provision of old age psychiatric services in nursing homes however, were recommended as part of the overall guideline of 40 beds per thousand population 65 years and over.

Long Term Care

Until recently, long term care in Newfoundland has generally been perceived as placement in a Senior Citizens Home and there has been an unrealistic expectation on the part of many community groups that these facilities should be provided in every community where there were Senior Citizens.

Although home care programs have been in place in several areas of the province for many years, most concentrated on provision of acute care. Recently however, some programs with a focus on long term/chronic care including home care, home support, day care, respite and meals on wheels have begun to develop. While these have helped a great deal in meeting the needs in some areas of Newfoundland and Labrador, these services have, unfortunately, been characterized by lack of coordination and have not been consistently available. These factors have encouraged an over-reliance on institutional care.

In addition, there is a maldistribution of both institutional and community services across the province.

As a result of the above, there are people living in institutions who could be discharged to live independently or semi-independently in sheltered housing in the community with appropriate support services. Others who need nursing home care are inappropriately placed in acute care hospitals or are living in unsatisfactory conditions in the community.

Chapter 4
GENERAL RECOMMENDATIONS

Despite the many good health care services that have been developed, there are shortfalls in the range of services in Newfoundland. If the trend towards reliance on institutional placement for the elderly and chronically ill and disabled is to be reversed, high priority must be given to development of a coordinated network of services aimed at keeping people in their own homes in their own communities. Such coordination requires major readjustments in the way services are delivered in Newfoundland. Jurisdictional boundaries at both government and local service delivery levels must be crossed, more choices must be available and resources must be reallocated to rehabilitation programs and service coordination. It is also essential that attitudes of health professionals and the general public change, particularly related to reliance on institutional care.

The general recommendations outlined below apply to the continuum of health care services in Newfoundland and are meant to augment the specific recommendations regarding the plans for Regional health care services which follow:

1. It is essential that comprehensive home care/home support services be developed throughout Newfoundland and Labrador. Steps should be taken to ensure that these services are not merely an add-on to existing services (as has been the case in many provinces) but rather, that they are viewed as an alternative to institutional services. Therefore, it is recommended that these services be fully developed and coordinated with other long term and acute care services and that their impact on the requirement for institutional beds and services be evaluated before expanding the number of beds for acute and long term care in the province.

   It is recommended that in some areas of the province (detailed in the following sections) test sites for Home Care/Home Support services be established.

2. The role of volunteers and non professionals who have been provided with training in basic nursing/personal care, should be expanded in home care to augment services provided by professional personnel.

3. Funds currently available and any new funds allocated for needs assessment should be directed towards assessment of the need for home care and other community support services.

4. Housing, particularly for seniors, should be coordinated with the provision of other long term care services and should be a provincial responsibility.

5. Sufficient numbers of sheltered housing alternatives should be developed throughout the province. Alternatives should include a range of options such as foster care, congregate apartments, personal care homes, etc. These must be of appropriate quality and provide services designed to meet the needs of each community. In the case of Licensed Boarding Homes (i.e. non Waterford Homes), standards should be upgraded and educational opportunities should be provided to operators particularly in homes where residents are primarily psychiatric or ex-psychiatric patients. Access to support services for residents of boarding homes is also critical. Consideration should be given to expanding services available through the Waterford Hospital such that they would be accessible to Boarding Home operators for education and support and to residents for programs.

6. More flexibility in funding is required to permit improvements in the range of health and social services available to meet the needs of Newfoundlanders. This will require improved organization of and coordination between Government Departments including Health, Education, Social Services, Housing and Transportation.

7. Information regarding preventive health benefits for senior citizens should be made more readily available to Seniors, their families and caregivers.

8. There should be an aggressive campaign to educate health care professionals and the general public to reduce over reliance on the health care system and on institutional placement for the elderly or chronically ill or disabled.

9. Preventive health educational programs aimed at lifestyle modification (especially related to smoking behaviour) should be promoted since lifestyle modification has led to significant reductions in morbidity and mortality for C.V.A.'s, etc.

10. In line with recommendation 5.29 of the Royal Commission report, education programs must be provided for staff working with long term care patients to improve their skills in encouraging independence.

11. Nursing homes should provide rehabilitation services to ensure that all residents function at the highest level possible. In addition, some nursing homes should develop services designed specifically for persons who may require nursing home care for a period of time, but who are capable of being rehabilitated to a point where they can return to the community when appropriate support services are available.

12. Comprehensive rehabilitation and psychiatric services should be developed on a regional basis.

13. In accordance with the recommendation of the Royal Commission, comprehensive assessment and placement services, preferably on a regional basis must be provided to ensure appropriate placement for all patients.

14. Nursing homes should provide a certain proportion of beds for respite care, short term emergency admissions and convalescent care. These beds should be over and above the beds allocated by the guideline of 40 beds per thousand population aged 65 and over. Global budgeting should make this feasible.

15. If funding of nursing home construction continues to occur through CMHC, the Government of Newfoundland and Labrador should supplement these funds to ensure provision of adequate space and programs (i.e. physiotherapy and occupational therapy) for residents and for outreach programs such as day care/day programs.

16. Expansions or new construction of nursing homes should be undertaken with the assistance of qualified health care planners knowledgeable in the appropriate programming and design of facilities for the elderly.

17. When construction is being considered for Nursing Homes, Hospitals and Health Centres, the facilities should be designed as multipurpose centres to include inpatient accommodations as well as ambulatory care facilities for acute and long term care. In addition, related services such as Public Health, Social Services and physician offices, etc. should be accommodated (where the need exists) within these centres.

18. Comprehensive education, prevention and treatment programs are required, especially for persons known to be at high risk, including diabetic and hypertensive patients, in order to reduce hospital and nursing home admissions.

19. Incentives should be developed to encourage physicians to alter their patterns of practice, in particular, as it relates to inpatient care. To encourage these changes in practice, the fee structure could be changed such that it would encourage:

    - participation in multi-disciplinary assessment and care for the elderly or patients with chronic disorders
    - use of outpatient services to replace inpatient services, especially preadmission diagnostic testing for medical cases
    - improvement in the consistency of visiting clinics
    - provision of services to isolated communities.

20. Appropriate facilities and staff should be provided to encourage reductions in inpatient utilization. It should be possible to accomplish this through reassignment of existing staff in institutions rather than through net increases in staff. In particular, further use of the following services is encouraged:

    - hostel*
    - day surgery
    - day hospital
    - outpatient counseling
    - coordinated preadmission diagnostic testing

21. Formalized discharge planning programs should be provided in all acute care hospitals.

22. Acute care beds should be reduced by at least 350. General rehabilitation beds should be increased by about 40. Levels II and III beds should be increased by about 530 of which approximately 75 will be created through conversion of level I beds and approximately 460 will be created through new construction.

    Note that 290 of the 460 beds recommended to be created through new construction have already been committed.

23. The Government should implement a program of ongoing needs evaluation for all levels of service. In particular, the need for all long term care services should be reviewed at three year intervals. An information base generated by the assessment and placement service will be an important factor in carrying out this evaluation.

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* Referral of patients by physicians to hostel facilities may be limited in situations where there is no pressure on hospital beds. Also, some physicians have indicated that they will not use hostel facilities for their patients if the patient is required to pay. In areas where patients are now required to pay for hostel accommodation however, such facilities are being well utilized. This issue may require further study.

Table 4.1

SUMMARY OF NET BED REDUCTIONS RECOMMENDED
ACUTE CARE

Region	Location	Facility	1984/85 Reported Acute Beds	Recom'd Acute Capacity	Net Reduction (Addition)
Labrador	Labrador City	Cptn Wm Jackman Mem'l. Hospital	47	43	4
	Goose Bay	Melville Hospital	45	45	0
	Total, Labrador		92	88	4
Northern	St. Anthony	C. S. Curtis Mem'l. Hospital	146	90-100*	46-56
	Port Saunders	Port Saunders Hospital	16	4	12
	Total, Northern		162	94-104	58-68
Western	Bonne Bay	Bonne Bay Hospital	20	2-4	16-18
	Corner Brook	Western Mem'l. Regional Hospital	267	267	0
	Stephenville	Sir Thomas Roddick	89	56	33
	Channel	Charles L. LeGrow	40	20	20
	Burgeo	Burgeo Hospital	18	6	12
	Total, Western		434	351-353	81-83
Central	Baie Verte	M.J. Boylen Hospital	31	25	6
	Springdale	Springdale Hospital	25	10	15
	Grand Falls	Central Nfld Reg'l. Hlth Centre	197	172	25
	Botwood	Botwood Cottage Hospital	46	0	46
	Buchans	A.M. Guy Memorial Hospital	12	2	10
	Harbour Breton	Harbour Breton Hospital	19	0	19
	Hbr Breton-St. Albans	New Facility	0	10	(+10)
	Twillingate	Notre Dame Bay Memorial Hosp.	53	37	16
	Fogo	Fogo Hospital	18	6	12
	Brookfield	Brookfield Hospital	30	10	20
	Gander	James Paton Memorial Hospital	162	134*	28
	Total, Central		593	406	187

Table 4.1

SUMMARY OF NET BED REDUCTIONS RECOMMENDED
ACUTE CARE (con't)

Region	Location	Facility	1984/85 Reported Acute Beds	Recom'd Acute Capacity	Net Reduction (Addition)
Eastern 1	Bell Island	Dr. W. Templeman Hospital	40	6	34
	St. John's Hospitals**	St. Clares Mercy Hospital	323		
		Health Sciences Centre	342		
		Grace General Hospital	292		
		Dr. C.A. Janeway Child Health Center	193		
	Subtotal, St. John's		1150	1185	(+35)
	Subtotal, Eastern 1		1190	1191	(+1)
Eastern 2	Old Perlican	Old Perlican Hospital	23	0	23
	Carbonear General	Carbonear General Hospital	100	100	0
	Placentia	Placentia Cottage Hospital	32	10	22
	Subtotal, Eastern 2		155	110	45
Eastern 3	Bonavista	Bonavista Cottage Hospital	15	15	0
	Grand Bank	Grand Bank Cottage Hospital	30	2-4	26-28
	Burin	Burin Cottage Hospital	31	0	31
	St. Lawrence	U.S. Memorial Hospital	22	0	22
	Salt Pond	New Hospital	0	60	(+60)
	Come by Chance	Come by Chance Cottage Hosp.	24	0	24
	Clarenville	Dr. G.B. Cross Hospital	0	60	(+60)
	Subtotal, Eastern 3		122	137-139	(+15-17)
	Total, Eastern		1467	1438-1440	27-29
	GRAND TOTAL		2748	2377-2391	357-371

* Excludes Rehabilitation Beds.

** Excludes Waterford and Children's Rehabilitation Centre.

Table 4.2

SUMMARY OF RECOMMENDATIONS GENERAL REHABILITATION BEDS

Region	Facility	Current Capacity (Rehab)	Recommended Capacity	Net Change
Northern	Charles S. Curtis Memorial Hospital	0	10	10
Western	Western Memorial Regional Hospital	8	24-30	16-22
Central	James Paton Memorial Hospital	0	10-12 (+8-10)*	10-12 (+8-10)*
Eastern	Miller Centre	30	30	0
	Total	38	74-82 (+8-10)	36-44

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* The consultants expect that in the long run an additional 8-10 Rehabilitation beds will be required in Gander. However, development of these beds will depend on the extent to which Rehabilitation services can be provided on an outpatient basis. Therefore, the need for these beds should be evaluated after inpatient and outpatient services are available.

Table 4.3

SUMMARY OF RECOMMENDATIONS
LEVEL I, II & III BEDS IN NURSING HOMES & HOSPITALS

Region & District	Facility	Total Capacity 1985/86	Level II-III Capacity		Level I Capacity		Respite Capacity	Additional Level II-III Beds			Levels I,II,III & Respite Capacity 1991 Recom'd
			1985/86	1991 Recom'd	1985/86	1991 Recom'd	1991 Recom'd	Through Conversion of Level I	Through New Constr'n*	Total	
Labrador & Northern Labrador	Harry L. Paddon Home	53	46	46	6	6	1	0	0	0	53
Northern	St. Anthony Interfaith	48	36	68	12	4	2	8	24	32	74
	Total, Labrador & Northern	101	82	114	18	10	3	8	24	32	127
Western Western A	Western Mem (Spec. Care)	60	52	60	0	0	0	8 **	0	8	60
	Corner Brook Interfaith	102	51	93	51	0	4-5	42	0	42	97-98
	Bonne Bay	0	0	29	0	0	1	0	29	29	30
	Burgeo	0	0	16	0	0	2	0	16	16	18
	Subtotal	162	103	198	51	0	7-8	50	45	95	205-206
Western B	Bay St. George	78	63	95-96	15	15	2-3	0	32-33	32-33	112-114
	Charles LeGrow Centre	18	18	16	0	0	2	0	0	0	18
	Subtotal	96	81	111-112	15	15	4-5	0	32-33	32-33	130-132
	Total, Western	258	184	309-310	66	15	11-13	50	77-78	127-128	335-338

Table 4.3
(con't)

Région & District	Facility	Total Capacity 1985/86	Level II-III Capacity		Level I Capacity		Respite Recom'd Capacity 1991	Additional Level II-III Beds			Recom'd Capacity 1991 Levels I,II,III & Respite
			1985/86	1991 Recom'd	1985/86	1991 Recom'd		Through Conversion of Level I	Through New Constr'n*	Total	
Central Central A	M.J. Boylen	8	8	8	0	0	2	0	0	0	10
	Valley Vista	104	67	90	36	12	2	23	0	23	104
	Subtotal	112	75	98	36	12	4	23	0	23	114
Central B	Carmelite House	102	83	35	19	73	2	-48	0***	-48	110
	A.M. Guy Mem'l. Hospital	18	18	17	0	0	1	0	0	0	18
	Botwood	0	0	73	0	0	2	0	73	73	75
	Subtotal	120	101	125	19	73	5	-48	73	25	203
Central C	New facility	0	0	30	0	0	2	0	30	30	32
	Subtotal	0	0	30	0	0	2	0	30	30	32
Central D	North Haven Manor	76	72	74	4	0	2	2	0	2	76
	Notre Dame Bay	15	15	32	0	0	3	0	19	19	35
	Subtotal	91	87	106	4	0	5	2	19	21	111
Central E	Lakeside Homes	123	88	111	35	0	7	23	0	23	118
	Bonnews Lodge	45	35	43	10	0	2	8	0	8	45
	Fogo	0	0	10	0	0	2	0	10	10	12
	Subtotal	168	123	164	45	0	11	31	10	41	175
	Total, Central	491	386	523	104	85	27	8	132	140	635

Table 4.3
(con't)

Region & District	Facility	Total Capacity 1985/86	Level II-III Capacity 1985/86	Level II-III Capacity 1991 Recom'd	Level I Capacity 1985/86	Level I Capacity 1991 Recom'd	Respite Recom'd Capacity 1991	Additional Level II-III Beds: Through Conversion of Level I	Additional Level II-III Beds: Through New Constr'n*	Additional Level II-III Beds: Total	Recom'd Capacity 1991 Levels I,II,III & Respite
Eastern Eastern 1A	Dr. W. Templeman Hospital	0	0	12	0	0	0	0	12	12	12
	Subtotal	0	0	12	0	0	0	0	12	12	12
Eastern 1B	Agnes Pratt	66	46	114	20	20	2	0	68	68	136
	Escasoni	191	189	187	2	2	2	0	-2	-2	191
	Glenbrook Lodge	146	104	102	42	42	2	0	-2	-2	146
	Hoyles Home	249	249	247	0	0	2	0	-2	-2	249
	Masonic Park	42	42	40	0	0	2	0	-2	-2	42
	St. Luke's	132	110	108	22	22	2	0	-2	-2	132
	St. Patrick's	214	214	212	0	0	2	0	-2	-2	214
	Subtotal	1040	954	1010	86	86	14	0	56	56	1110
Eastern 2A	Carbonear Interfaith	55	53	53	0	0	2	0	0	0	55
	Harbour Lodge	98	98	146	0	0	2	0	48	48	148
	Pentecostal Home	102	57	46	45	49	0	-7	0	-7	95
	Subtotal	255	208	245	45	49	4	-7	48	41	298
Eastern 2B	Lions Manor	75	75	70	0	0	5	0	-5	-5	75
	Subtotal	75	75	70	0	0	5	0	-5	-5	75

Table 4.3
(con't)

Region & District	Facility	Total Capacity 1985/86	Level II-III Capacity		Level I Capacity		Respite Recom'd Capacity 1991	Additional Level II-III Beds			Recom'd Capacity 1991 Levels I,II,III & Respite
			1985/86	1991 Recom'd	1985/86	1991 Recom'd		Through Conversion of Level I	Through New Constr'n*	Total	
Eastern 3A	Golden Heights Manor	47	46	85	1	0	2	1	38	39	87
	Subtotal	47	46	85	1	0	2	1	38	39	87
Eastern 3B	New Hosp. - Salt Pond	0	0	15	0	0	0	0	15	15	15
	Blue Crest Interfaith	94	68	84	26	8	2	16	0	16	94
	Subtotal	94	68	99	26	8	2	16	15	31	109
Eastern 3C	Dr. G.B. Cross Hospital	0	0	15	0	0	0	0	15	15	15
	New nursing home	0	0	50	0	0	2	0	50	50	52
	Subtotal	0	0	65	0	0	2	0	65	65	67
	Total, Eastern	1511	1351	1586	158	143	29	29	229	239	1758
	GRAND TOTAL	2361	2003	2532-2533	346	253	70-72	76	462-463	538-539	2855-2858

* Includes reallocation from acute care.

** Conversion from Rehabilitation to Level II-III.

*** 15 beds are achieved through new construction but these replace existing beds.

Note: Beds recommended at Burgeo, new facility in Central C, Fogo and Clarenville (new nursing home) may change depending on success of Home Care/Home Support. Numbers should be reviewed before construction occurs.

REGIONAL PLANS

Following is an outline of the requirements for acute and long term care services and a brief discussion of the recommendations for each region in the province. This information is provided as a summary only and should not be considered in isolation from the analysis and detailed recommendations contained in the main report.

There are four Regions in Newfoundland and Labrador which are comprised of a number of health care districts. These districts were used by the consultants as a basis for planning health care services as follows:

1. **Labrador Region** is comprised of two districts:

   Labrador City - Labrador City, Churchill Falls, Wabush.
   Coastal Labrador - Goose Bay/Happy Valley and coastal communities.

2. **Northern Region** is one district comprised of the entire Northern Peninsula of the province.

3. **Western Region** is comprised of two districts:

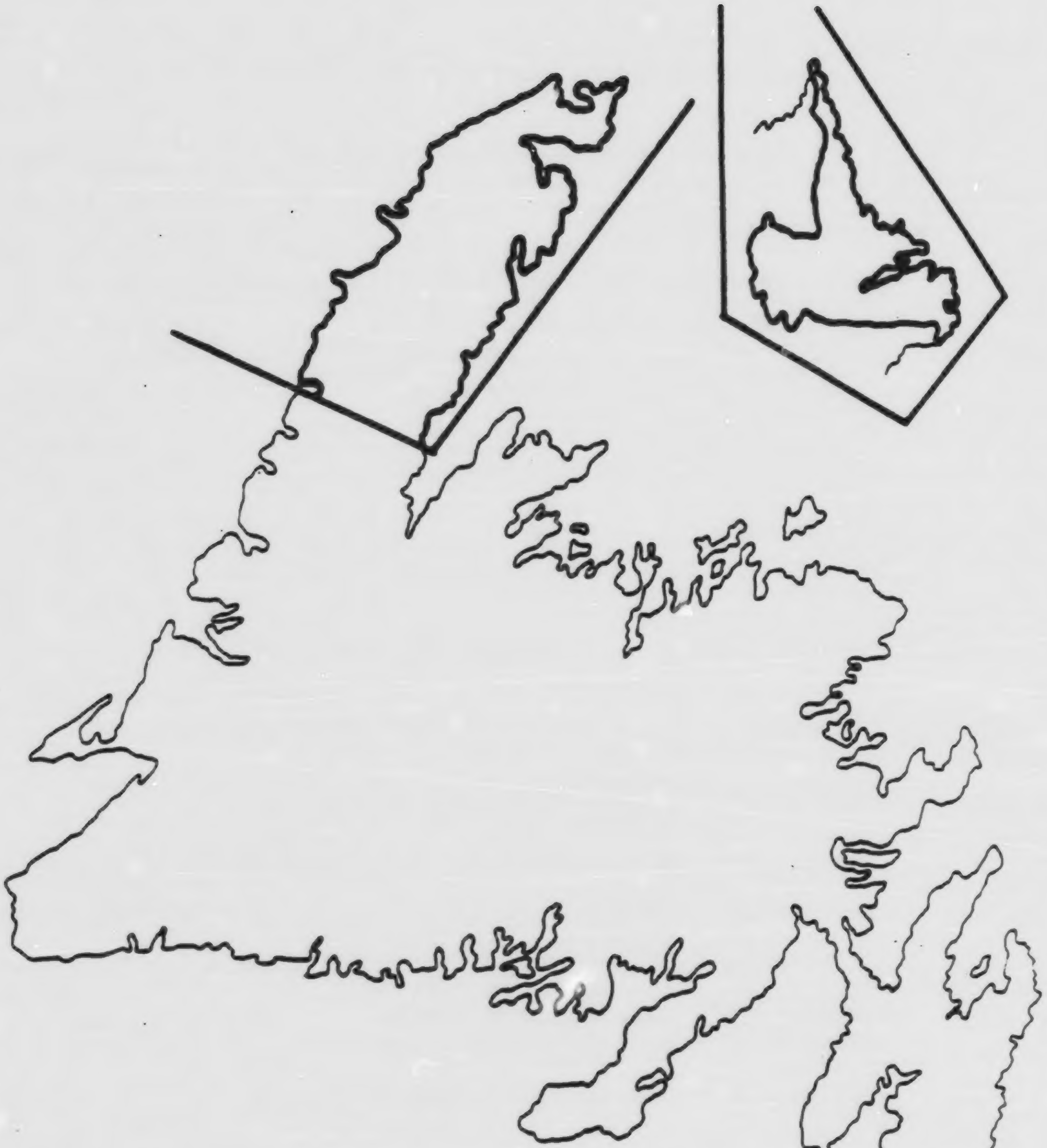
   Western A - Corner Brook, Bonne Bay, Burgeo, Hampden.
   Western B - Stephenville, Channel.

4. **Central Region** is comprised of five districts:

   Central A - Baie Verte, Springdale
   Central B - Grand Falls, Buchans, Botwood
   Central C - Harbour Breton, St. Albans
   Central D - Lewisporte, Twillingate
   Central E - Gander, Fogo, Brookfield

5. **Eastern Region** is comprised of seven districts:

   Eastern 1A - Avalon (includes Bell Island, Conception Bay South, Goulds, Kilbride)
   Eastern 1B - St. John's, Greater St. John's
   Eastern 2A - Bay de Verde Peninsula
   Eastern 2B - Southwestern Avalon
   Eastern 3A - Bonavista Peninsula
   Eastern 3B - Burin Peninsula
   Eastern 3C - Clarenville, Come By Chance



LABRADOR AND NORTHERN REGIONS

Application of the norms of 3.15 - 3.60 beds per thousand population for acute care, .2 beds per thousand population for rehabilitation, 40 beds per thousand population 65 and over for level II - III care and 30 beds per thousand population 65 and over for level I care to the 1986 population yields the following bed numbers. Note that these are maximum numbers which may be reduced through use of comprehensive home care/home support services and other alternatives to institutional care.

Summary of Beds Required and Beds Available* 1986

Region	Acute Care Beds		Rehab. Beds		Level II-III Beds		Level I Beds	
	Req'd	Avail**	Req'd	Avail	Req'd	Avail	Req'd	Avail
Labrador	97-111	88		0	16	46	12	16
Northern	62-71	162***	10****	0	59	36	44	32

* Beds in Nursing Stations/Health Centres excluded.
** Acute care beds available are based upon beds in operation at time of consultants' visit or on information received from hospital since then and therefore may be different than numbers shown on Table 4.1.
*** Includes 16 psychiatric beds at Curtis Memorial Hospital staffed only 18 hours per day.
**** Applies to beds required for Labrador and Northern Regions combined.

Projected Bed Requirements

By 1991, the requirement for acute care beds in Labrador is projected to decrease very slightly to 96 - 109 and to 92 - 105 by 2001. In the Northern Region, the requirement for acute care beds is projected to rise slightly by 1991 to 65 - 74 beds and then to drop back to 62 - 71 beds by 2001.

The requirement for rehabilitation beds is projected to stay at 10 for the Labrador and Northern Regions over the next 5 years.

According to the norms, it is projected that by 1991, Labrador will require 19 level II and III beds and 14 level I beds. In the Northern Region, it is projected that 67 level II - III beds and 50 level I beds will be required by 1991. It is anticipated

Discussion & Recommendations

Labrador

Home Care/Home Support Services

It is recommended that home care and home support services be developed to meet the needs of residents throughout the Coastal Labrador district.

Labrador City

Captain William Jackman Hospital

No change in capacity is recommended.

Goose Bay/Happy Valley and Coastal Labrador

Melville Hospital

No change in the total number of beds is recommended.

Harry L. Paddon Memorial Home

No change in the total number of beds is recommended.

Other Services

Transition House/Group Home

It is recommended that a transition house/group home be developed in the Goose Bay/Happy Valley area for persons from this area who have psychiatric illnesses and who are frequently admitted to the Melville and Waterford Hospitals due to unstable living conditions.

Coastal Labrador

No change in the capacity of the nursing stations is recommended.

Northern

Home Care/Home Support Services

Comprehensive home care and homemaker services should be developed as a priority throughout the Northern Region.

St. Anthony

Charles S. Curtis Memorial Hospital

The consultants believe that there is potential for significant reduction in the numbers of beds at this hospital. The size of the reduction which can be achieved however, is highly dependent upon several factors including improvements in transportation, changes in medical referral patterns, the success of Home Care and Home Support services in the region (especially in view of the isolation in the Northern Region) and the development of alternatives to hospitalization such as hostel accommodations. The impact of these on bed requirements can only be evaluated over time, hence only limited reductions may be possible in the short term.

The development of comprehensive home care and home support services has been recommended above and should be vigorously pursued in the immediate future as should development of hostel facilities. Also in the medium to long term, a 10 bed General Rehabilitation unit to serve the Labrador and Northern regions should be established here.

Based on the consultants' analysis of utilization information for this hospital and on the development of services discussed above, the consultants recommend that the bed capacity be reduced over time from 134 to 100-110 (including the 10 bed Rehabilitation unit).

St. Anthony Interfaith Home

It is recommended that over time 20 - 24 beds for level II and III care be added to this Home and that as many as possible of the beds now used for level I care, be converted for level II - III use. Ten to twelve of the new beds should be appropriate for old age psychiatric care.

Two beds at this Home should be designated for respite care, short term emergency admissions and convalescent care.

Northern

Level I Facilities

Beds appropriate for level I care should be expanded by 20 - 26 over the next few years in this region and should be closely associated with St. Anthony Interfaith Home.

Port Saunders

Port Saunders Hospital

In the long term, it is recommended that this hospital be replaced with a facility to provide 4 beds for holding/ observation purposes and space for ambulatory clinics similar to that at Flowers Cove.

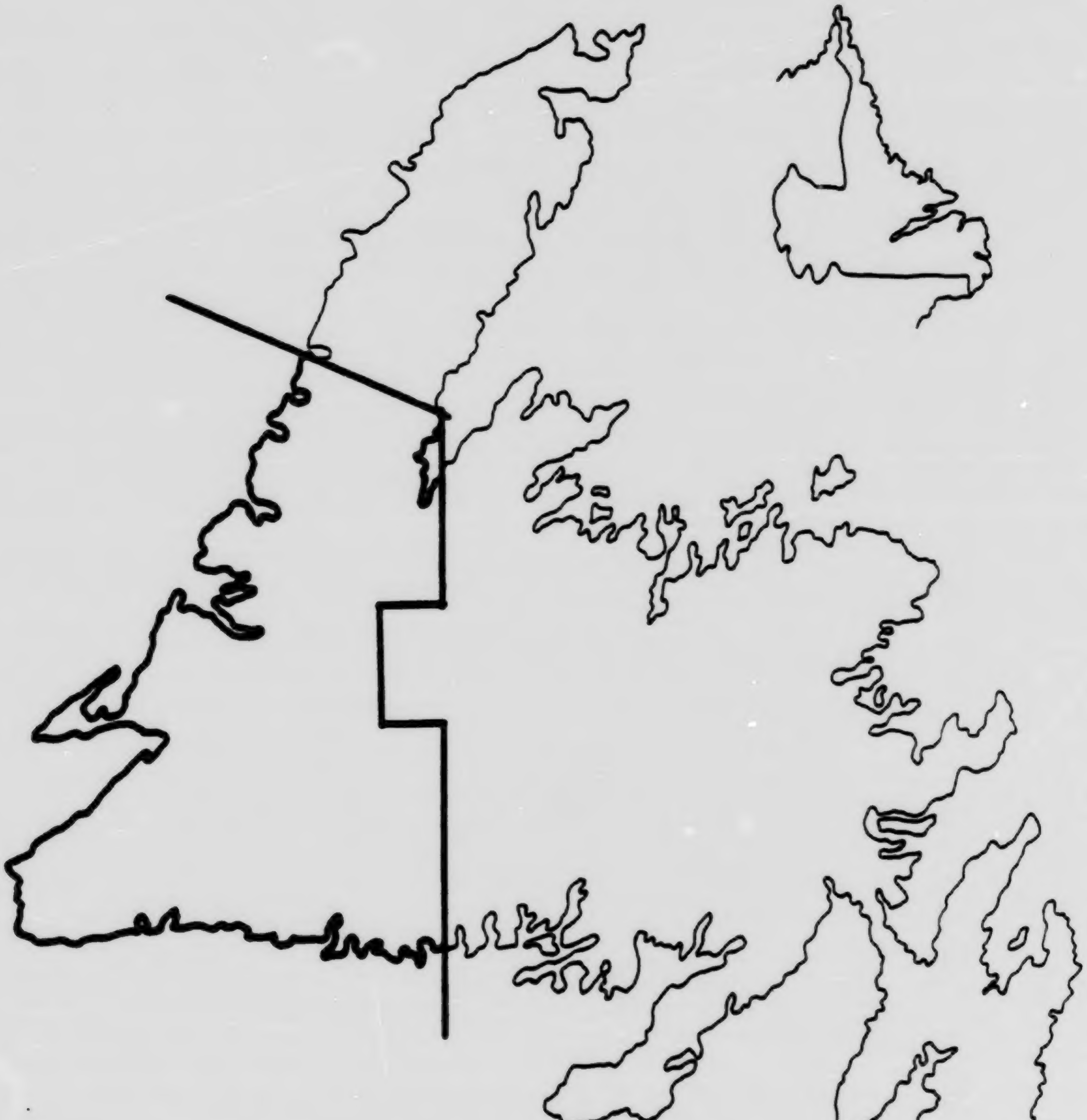
It is also recommended that if the reduction in beds discussed above is achieved, consideration be given to developing 6 - 12 level I beds in this area.

Flowers Cove

No change in the capacity of the Health Centre is recommended.

Roddickton

The nursing station in Roddickton should be replaced by one similar to that located in Flowers Cove.



WESTERN REGION

Application of the norms of 3.15 - 3.60 beds per thousand population for acute care, 0.2 beds per thousand population for rehabilitation, 40 beds per thousand population 65 and over for level II - III care and 30 beds per thousand population 65 and over for level I care to the 1986 population yields the following bed numbers. Note that these are maximum numbers which may be reduced through use of comprehensive home care/home support services and other alternatives to institutional care.

Summary of Beds Required and Beds Available 1986

Acute Care Beds		Rehab. Beds		Level II-III Beds		Level I Beds	
Req'd	Avail*	Req'd	Avail	Req'd	Avail	Req'd	Avail
306-350	412**	24	8	288	182	216	124

* Acute care beds available are based upon beds in operation at time of consultants' visit or on information received from hospital since then and therefore may be different than numbers shown on Table 4.1.

** Includes 16 beds temporarily in use for long term care.

Projected Bed Requirements

By 1991, the requirement for acute care beds in the Western Region is projected to rise slightly to 308 - 352 and to 317 - 362 by 2001. The requirement for rehabilitation beds is projected to be the same in 1991 as in 1986. It should be noted however, that if it is not deemed feasible to develop the rehabilitation unit recommended for the Northern and Labrador regions, it is recommended that the unit in the Western region provide 30 beds rather than the 24 beds noted above.

According to the norms, it is projected that by 1991, the Western region will require 327 level II - III beds and 246 level I beds. It is anticipated however, that the provision of comprehensive home care/home support services will reduce these numbers.

Discussion and Recommendations

Home Care/Home Support Services

It is recommended that the development of comprehensive, well coordinated Home Care and Home Support services be considered as a priority throughout the entire Western Region.

Western A - Bonne Bay, Corner Brook, Burgeo

Bonne Bay

Bonne Bay Hospital

No change in capacity is recommended in the short run. However when this facility is replaced, it is recommended that 2 - 4 beds for holding/observation purposes, 24 hour clinic facilities and 24 - 30 beds for level II - III care be provided.

Level I Facilities

It is recommended that 12 - 18 level I beds be developed in the Bonne Bay area.

Corner Brook

Western Memorial Hospital

No change in the current capacity of 267 acute care beds is recommended. However, a Rehabilitation Unit of 24 beds (or 30 beds depending upon whether a Rehabilitation Unit is developed at Curtis Memorial in St. Anthony) should be developed as soon as funding is available.

Hostel facilities should be expanded to relieve pressure on inpatient beds.

Western Memorial Special Care Unit

When the Rehabilitation Unit at the Hospital is opened, the 8 beds now used for Rehabilitation in the Special Care Unit should revert to long term care use. This would bring the number of beds for level II - III care up to 60 at this facility.

Renovations are required to make this facility more appropriate for level II - III care and additional physio, occupational and recreation therapy staff are required.

Corner Brook Interfaith Home

It is recommended that if structurally feasible, this facility be renovated to provide 93 beds for level II - III care and 4 - 5 beds for respite, convalescent care and short term emergency admissions from the community.

Level I Facilities

It is recommended that an additional 12 beds for level I care be provided in this area.

Burgeo

It is recommended that Burgeo and surrounding coastal communities be developed as a test site for comprehensive home care and home support services. **These must be fully funded to ensure consistent, reliable services are provided.**

It is recognized that effective provision of Home Care/Home Support services in this area will not be easy due to the isolation of the communities and the difficulties experienced in traveling between them. However we felt it important that these services be tested in all settings throughout Newfoundland and Labrador. In order to maximize the efficiency with which these services can be provided, it is recommended that a resident(s) of each community be provided with basic training in home nursing and that a professional be employed as a Coordinator of services to the various communities.

Replacement facilities for Burgeo Hospital are required and planning should begin to provide six acute care beds, two beds for respite, ambulatory clinic facilities and possibly office space for public health and social services personnel (and eventually beds for long term care). However, it is recommended that before the long term care phase of construction is begun, an evaluation of the impact of home care services on the need for institutional beds for long term care be conducted. The need for level I beds should be evaluated at the same time.

In the short term, it is recommended that the hospital consider development of a meals on wheels program and that a staff member be trained as a physiotherapy aide. Two beds in the current hospital should be formally designated for respite and convalescent care and short term emergency admissions from the community.

Western B - Stephenville - Channel

Stephenville

Sir Thomas Roddick Hospital

The development of home care and home support services coupled with the opening of additional level II - III beds at Bay St. George Senior Citizens Home should relieve pressure on beds at this hospital. It is recommended that pediatric beds be reduced and that the 16 beds now occupied full time by long term care patients be closed when the beds at the Senior Citizens Home open. The recommended reduction in bed capacity from 89 to 56 should permit increased flexibility in the use of space at this hospital.

Bay St. George Senior Citizens Home

In line with the requirement for level II - III beds in Western B (calculated by application of the guidelines of 40 beds per thousand 65 years and over), it is recommended that only 35 beds of the 50 bed addition now under construction be opened. Funds which have been budgeted for operation of the remaining 15 beds should be allocated to the provision of comprehensive home care and home support services in the Stephenville - Port aux Port Peninsula areas. Two to three beds are recommended for respite and convalescent care and short term emergency admissions from the community.

Channel

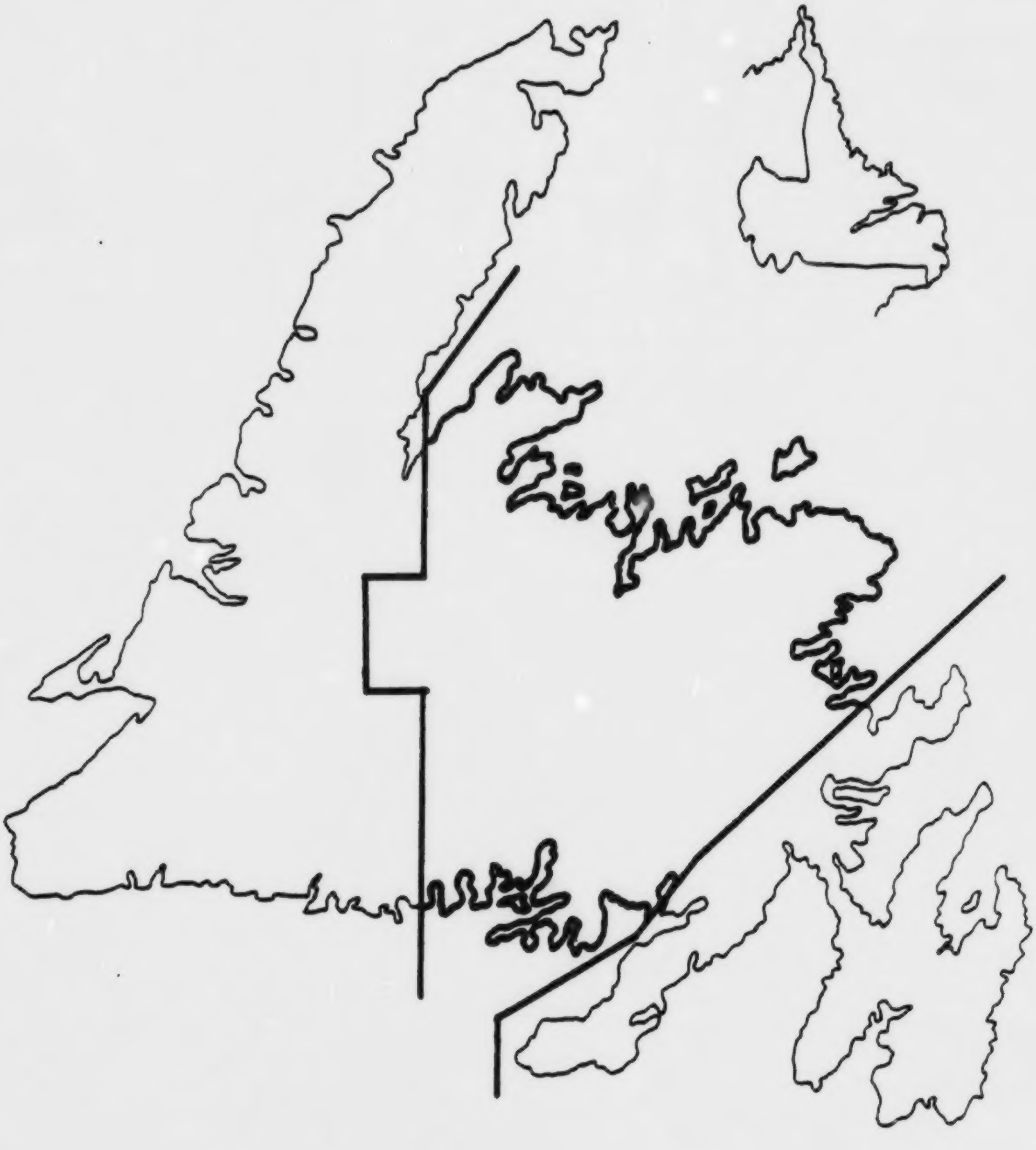
Charles L. LeGrow Health Centre

It is recommended that this facility retain its current capacity of 20 acute care beds, 16 level II - III beds and 2 respite beds.

Western B

Level I Facilities

Level I beds are very limited in the Western B district (7 beds). According to the norm, this district could support up to 82 level I beds, however it is anticipated that the need for these beds will be affected by the availability of comprehensive home care and home support services. Therefore, in the short term it is recommended that 24 level I beds be developed in Western B and that the need for additional beds be evaluated after home care and home support services are available throughout the district.



CENTRAL REGION

Application of the norms of 3.15 - 3.60 beds per thousand population for acute care, .2 beds per thousand population for rehabilitation, 40 beds per thousand population 65 and over for level II - III care and 30 beds per thousand population 65 and over for level I care to the 1986 population yields the following bed numbers. Note that these are maximum numbers which may be reduced through use of comprehensive home care/home support services and other alternatives to institutional care.

Summary of Beds Required and Beds Available 1986

Acute Care Beds		Rehab. Beds		Level II-III Beds		Level I Beds	
Req'd	Avail	Req'd	Avail	Req'd	Avail	Req'd	Avail
395-451	546*	25	0	443	381	332	208

* Acute care beds available are based upon beds in operation at time of consultants' visit or on information received from hospital since then and therefore may be different than numbers shown on Table 4.1.

Projected Bed Requirements

By 1991 the requirement for acute care beds is projected to increase very slightly to 399 - 456 and to 409 - 468 by 2001. According to the norms, the requirement for long term care beds is projected to increase substantially to 505 in 1991 for levels II and III and to 377 in 1991 for level I. It is anticipated however, that the provision of comprehensive home care/home support services will reduce these numbers.

Discussion & Recommendations

Home Care/Home Support Services

The development of comprehensive home care and home support services throughout Central Region should be considered a priority.

Central A - Baie Verte - Springdale

Baie Verte

M.J. Boylen Hospital

The acute care bed capacity of this hospital should be reduced from 31 to 25 - 27 beds.

Springdale

Springdale Hospital

The acute care bed capacity should be reduced from 25 to 10 beds.

Valley Vista

No change in capacity is recommended, however 24 level I beds should become level II - III beds.

Central A

Level I Facilities

At least 10 - 12 beds for level I care are required in this district, preferably in the Baie Verte area.

Central B - Grand Falls, Buchans, Botwood

Grand Falls

Central Newfoundland Regional Health Centre

Based upon the development of hostel facilities, improvements in Home Care and Home Support services, and access to beds for long term and convalescent care at the new facility planned for Botwood, the consultants believe that there is potential to reduce the number of beds at this facility over time from 208 to 172. The requirement for inpatient psychiatric beds at this hospital in the future however, is not clear and an increase in these beds may be required when the full impact of the tripartite agreement for distribution of clinical services, formalized by the Department of Health and the Boards of James Paton Hospital in Gander and the Central Newfoundland Regional Health Centre in Grand Falls, becomes obvious.

In order to permit some of this reduction to occur as soon as possible, it is recommended that construction of the planned hostel be considered a priority.

Carmelite House

Renovations and new construction are required to replace current facilities which are inappropriate for level II and III care. This project should result in a reduction in capacity of level II - III beds from 83 to 35 and an increase in level I beds from 19 to 73. While the recommended increase in level I beds at this facility is inconsistent with the recommendations to decrease level I beds at other nursing homes, it is considered by the consultants to be appropriate for this facility. Carmelite House was a hotel prior to its conversion for use as a nursing home and because of its configuration, is much more appropriate for level I care than levels II or III. Since there was a need for level I beds in this district, it seemed most appropriate to recommend that the existing structure be put to use as a facility in which ambulatory persons could receive the care they require.

Buchans

A. M. Guy Hospital

No change in the current capacity of 20 beds is recommended. However, in view of the recent change in role from acute to long term care, appropriate programs must be developed to meet the social, psychological and recreational needs of the patients accommodated here. Education and orientation of staff regarding the needs of long term care patients is also essential.

Botwood

Botwood Hospital

Thirty to thirty five of the 75 beds planned for this new facility should be designated for old age psychiatric services. Of the remaining 40 - 45 beds, Central Newfoundland Regional Health Centre should have priority access to 25 for long term and convalescent care purposes. The existing Botwood Hospital should be closed as an inpatient facility when the new nursing home opens.

Central C - Harbour Breton - St. Albans

Harbour Breton - St. Albans

It is recommended that Central C district be developed as a test site for comprehensive home care and home support services. **These must be fully funded to ensure consistent, reliable services are provided.**

It is recognized that effective provision of Home Care/Home Support services in this area will not be easy due to the isolation of the communities and the difficulties experienced in traveling between them. However, we felt it important that these services be tested in all settings throughout Newfoundland and Labrador. In order to maximize the efficiency with which these services can be provided, it is recommended that a resident(s) of each community be provided with basic training in home nursing and that a professional be employed as a Coordinator of services to the various communities.

New facilities for acute and ambulatory care are needed to serve the population of this district as are long term care facilities. It is recommended that planning be undertaken for the construction of the acute care and ambulatory care phase of the health care centre. Ten beds should be adequate to meet the need for acute care services. Two beds should also be provided for respite and convalescent care and short term emergency admissions from the district.

According to the norms, the 1991 projected population of this area could support 30 - 40 level II - III beds and up to 27 level I beds. The development of comprehensive home care/home support services however is expected to reduce the need for institutional beds. Therefore, it is recommended that before the addition of long term care facilities is undertaken, an evaluation of the impact of home care/home support be carried out.

In the short term, two beds should be formally designated for respite and convalescent care and short term emergency admissions from the district.

Central D - Lewisporte - Twillingate

Lewisporte

North Haven Manor

No change in bed capacity is recommended. Expansion of day care and outreach services is however, recommended. This will require expansion of facilities and additional personnel.

Level I Facilities

Additional level I beds are not recommended in the short run.

Twillingate

Notre Dame Bay Memorial Hospital

It is recommended that additional space and resources be provided for long term care through relocation of Intensive Care to a two bed room on the medical unit and closure of the pediatric unit. Programs and recreational activities for long term care residents should be developed and in view of the change in responsibilities, staff should be provided with educational opportunities to ensure they are well oriented to the provision of long term, rather than acute care.

In summary, it is recommended that the acute care capacity be reduced from 54 to 37 beds and if feasible, the long term care capacity should be increased to 35. Three of these beds should be designated for respite and convalescent care and short term emergency admissions.

Level I Facilities

Provision of a nursing home in Twillingate is not recommended. However, development of one or two 6 bed facilities for level I care should be considered.

Central E - Gander - Fogo - Brookfield

Gander

James Paton Memorial Hospital

The transfer of psychiatry to the Central Newfoundland Regional Health Centre, combined with development of hostel facilities in this area should permit a reduction in the acute care capacity from 157 to 134 beds. It is recommended that a rehabilitation unit of 10 - 12 beds initially, but with potential for expansion, be provided here. These beds should be in addition to the 134 beds recommended for acute care.

Lakeside Homes

A slight reduction in capacity is recommended to provide adequate recreational space in the old age psychiatric unit. Beds now occupied by level I residents should gradually become occupied by level II - III residents.

Central E

Level I Facilities

Development of facilities for up to 20 level I beds in the Eastport - Glovertown part of the district is recommended.

Fogo

It is recommended that Fogo Island be developed as a test site for comprehensive home care and home support services. **These must be fully funded to ensure consistent, reliable services are provided.**

Over the next 5 - 10 years, Fogo Hospital should be replaced with a new multipurpose health care centre to provide 6 beds for acute care, 2 beds for respite and convalescent care and short term emergency admissions from the community, ambulatory clinic facilities and beds for level II - III care. Although 10 level II - III beds could be supported by the population of Fogo, it is anticipated that the presence of well developed home care/home support services may reduce the requirement for long term care beds. Therefore an evaluation of the need for such services should be carried out before construction begins.

Level I Facilities

A 6 bed licensed boarding home or congregate living facility should be considered for Fogo Island. This should relate very closely to the hospital.

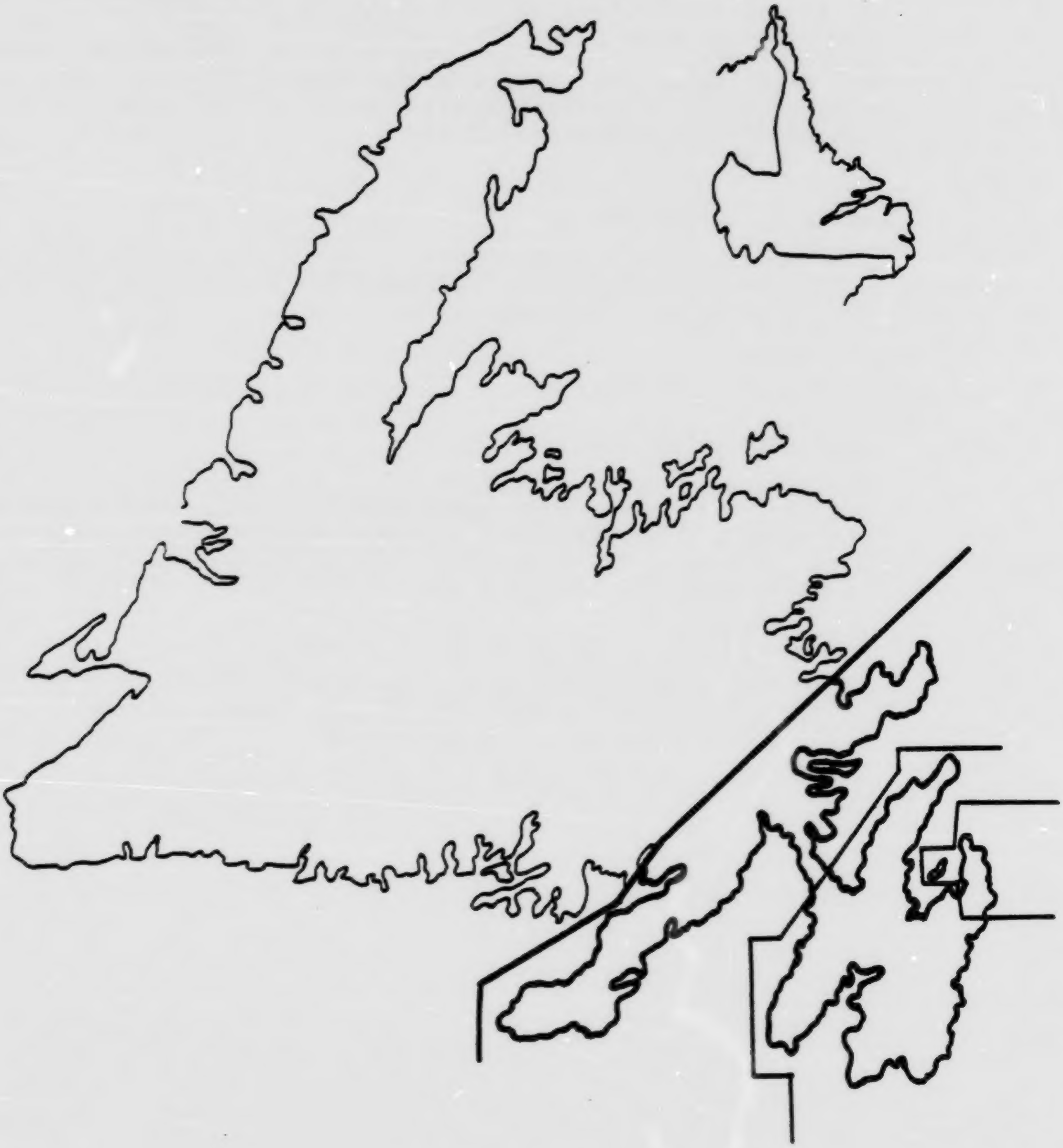
Brookfield/Valleyfield

Brookfield Hospital

Improved ambulatory care facilities are required for this hospital. This may be accomplished through renovation and/or new construction and when this is done, the acute care capacity should be reduced from 30 to 10 beds. Emergency and other appropriate services should be accommodated.

Bonnews Lodge

No change in bed capacity is recommended. However, beds now occupied by level I residents should gradually become occupied by level II - III residents.



EASTERN REGION

Application of the norms of 3.15 - 3.60 beds per thousand population for acute care, .2 beds per thousand population for rehabilitation, 40 beds per thousand population 65 and over for level II - III care and 30 beds per thousand population 65 and over for level I care to the 1986 population yields the following bed numbers. Note that these are maximum numbers which may be reduced through use of comprehensive home care/home support services and other alternatives to institutional care.

Summary of Beds Required and Beds Available 1986

Acute Care Beds		Rehab. Beds		Level II-III Beds		Level I Beds	
Req'd	Avail	Req'd	Avail	Req'd	Avail	Req'd	Avail
1233-1401	1396*	62	50	1206	1391	907	962

* Acute care beds available are based upon beds in operation at time of consultants' visit or on information received from hospital since then and therefore may be different than numbers shown in Table 4.1.

Projected Bed Requirements

By 1991, the requirement for acute care beds will increase to 1269 - 1443 and to 1275 - 1450 by 2001. This region should be close to the lower end of the range. The requirement for general rehabilitation beds is projected to increase to 64 in 1991 and to 65 in 2001.

According to the norms, by 1991 this region will require 1373 level II and III beds and 1029 level I beds. It is anticipated however, that the provision of comprehensive home care/home support services will reduce these numbers. Although there is an excess of beds for all levels of care except rehabilitation in the region, this excess occurs in the St. John's and Eastern Avalon area. There is therefore a maldistribution within the region. This will to some extent be corrected with the construction of facilities at Clarenville and in the Burin and Bonavista peninsulas.

Discussion & Recommendations

Home Care/Home Support Services

High priority should be given to development of comprehensive home care/home support services throughout the entire Eastern region.

Eastern 1A - Avalon (includes Bell Island, Conception Bay South, Kilbride, Goulds, etc.)

Bell Island

Dr. Walter Templeman Hospital

This hospital should reduce its acute care beds from 40 to 6. It should convert the remaining acute care beds to provide 12 level II - III beds and 2 respite beds.

Eastern 1A

Level I Facilities

There is a surplus of boarding home beds on the Avalon Peninsula. As opportunities occur the excess beds should be eliminated.

Eastern 1B - St. John's, Greater St. John's

St. John's

Since the overall allocation of acute care beds among the St. John's hospitals is the subject of a study being conducted by the St. John's Hospital Council, this was not addressed by the consultants. However, utilization information for these hospitals was reviewed and discussions were held with staff of these and other hospitals in the province from which the consultants concluded that the 1185 beds recommended by the Royal Commission for adult general hospitals in St. John's will be more than adequate until 2001.

No changes in bed capacities are recommended for St. John's nursing homes. However each nursing home in St. John's should designate at least 2 beds for respite and convalescent care and short term emergency admissions from the community.

Eastern 2A - Bay de Verde Peninsula

Carbonear

Carbonear General Hospital

This hospital should operate at its rated capacity of 100 beds. When the acute care beds at Old Perlican close, the need to open 5 - 6 additional beds at Carbonear General Hospital should be reviewed.

Harbour Lodge

The 50 beds under construction will create a total capacity of 148 beds at this facility. The addition of beds should permit it to become more of a local resource serving residents of the Bay de Verde Peninsula.

Carbonear Interfaith Home

No change recommended.

Old Perlican

Old Perlican Hospital

This hospital is no longer suitable for acute care and is not appropriate for provision of long term care. In the medium term, it should be replaced. Since Carbonear General Hospital has adequate capacity to meet the needs for acute care beds in this district, only ambulatory care facilities should be needed at Old Perlican in the future. Consideration should be given to relocating the Developmental Maximization Unit and providing ambulatory care and diagnostic services in appropriately designed facilities. Holding beds may be considered.

Clarke's Beach

Pentecostal Home

Because of overcrowding the capacity of this home should be reduced to 95 beds. Outreach services should be developed. The home should undergo a renovation program to provide facilities suitable for all level II and III care. Such renovations are expected to reduce the capacity further, to approximately 75 beds.

Eastern 2A

Level I Facilities

No additional level I beds should be provided in this district.

Eastern 2B - Southwestern Avalon

Placentia

Placentia Cottage Hospital

This hospital should be replaced when funds are available. The new facility should provide a maximum of 10 acute care beds.

Lions Manor

It is recommended that only 50 of the 75 beds in this new facility be opened and that funds budgeted for the operation of the other 25 beds be allocated to the development of community home care/home support services.

Eastern 2B

Level I Facilities

Although there is a deficit of level I beds in this part of the region, the surplus on the Avalon as a whole indicates that no additional level I beds should be provided at this time.

Eastern 3A - Bonavista Peninsula

Bonavista

Bonavista Cottage Hospital

The capacity of this hospital should remain at 15 beds.

Golden Heights Manor

This home has received approval to construct 40 additional beds. Two of these should be designated for respite, convalescent care and emergency placement. Construction should provide appropriate facilities for physiotherapy and occupational therapy activities.

Eastern 3A

Level I Facilities

Up to 20 level I beds should be developed in this district in the near future and an additional 20 could be developed after the initial group are accepted and evaluated. This should be evaluated in light of the availability of Home Care/Home Support services.

Eastern 3B - Burin Peninsula

Burin

Burin Hospital

This hospital should cease to function as an inpatient facility when the new hospital in Salt Pond opens.

Salt Pond

New Hospital

No changes are recommended to the planned capacity of 60 acute care and 15 long term care beds at this new hospital.

St. Lawrence

U.S. Memorial Hospital

This hospital should cease to provide inpatient care when the new hospital in Salt Pond opens.

Grand Bank

Grand Bank Cottage Hospital

This hospital should cease to provide inpatient care when the new hospital in Salt Pond opens. An ambulatory care facility with 2 - 4 holding beds should be constructed in the Grand Bank area. Location of such facilities close to Blue Crest Interfaith Home should be considered as one option if a suitable site with good access routes can be otained.

Blue Crest Interfaith Home

No changes are recommended in the capacity of this home at this time. Over the next few years the beds occupied by level I residents should be converted for level II - III residents.

Eastern 3B

Level I Facilities

Up to 40 level I beds should be planned in this district over the next few years however. This should be evaluated in light of the availability of Home Care/Home Support services. These beds should be distributed throughout the district and in particular, some should be located in or near the towns of St. Lawrence and Burin.

Eastern 3C - Clarenville, Come by Chance

Clarenville

Dr. G. B. Cross Hospital

No changes are recommended to the planned capacity of 60 acute care and 15 long term care beds at this new hospital.

Level II-III Facilities

According to the norm, there is a need for level II-III beds in this area. The consultants have been advised that 15 long term care beds are planned for the new Dr. G. B. Cross Hospital. These beds should be opened during fiscal 1986/87 and resources should be committed to the development of comprehensive home care/home support services. The impact of these services on the need for long term care beds should be evaluated before building a new facility in this area.

It is anticipated that as a result of home care/home support services, the number of beds required will be fewer than indicated by application of the norm. However it seems likely that a facility of up to 50 beds in addition to the 15 beds at the Dr. G. B. Cross Hospital, will be required. Planning should begin for this before 1990.

Come By Chance

Come by Chance Hospital

The Come by Chance Hospital should cease to provide inpatient care when the new hospital opens in Clarenville. Ambulatory care facilities however, will continue to be required in this area.

Eastern 3C

Level I Facilities

No additional level I beds are required in this district.

Appendices

PRIORITIES

The consultants were asked to identify priorities for the development of facilities and services for acute and long term care. **First and foremost, the Consultants recommend that before any more beds are provided, it is essential to ensure that the beds currently available are being used appropriately. Also Home Care/Home Support services should be well developed throughout the province before providing additional beds as these services may reduce the number of beds required below that indicated as per the norms.**

Based on this, the Consultants have identified priorities in two groups. The first grouping identifies priorities for development of test sites for Home Care/Home Support Services, Level II - III and acute care facilities. The second grouping identifies priorities for the development of level I facilities.

Those areas in which the greatest needs were identified through a combination of deficits to the norm, and information obtained during the consultants visits were given the highest priority. In assigning priorities, consideration was also given to availability of other services and the extent to which level I beds in nursing homes are expected to be reassigned for level II and III care in the future.

In the case of level I services, priorities were based upon the assumption that a maximum of six beds will be licensed in one facility (as recommended by the Royal Commission) and that a limited number of beds will be licensed by the province. Although there is currently no waiting list and there are vacancies in some licensed boarding homes in the province, a limited number of beds have been recommended in order to begin to correct the problem of maldistribution of these beds throughout the province. It should be noted however, that bed numbers shown do not reflect the totals recommended in the regional plans.

Priorities for Development of Home Care/Home Support Level II - III and Acute Care Facilities

Following are the recommended priorities for development of test sites for Home Care/Home Support services, level II - III and acute care facilities.

The priority groups are as follows:

Group I - To be planned and developed as soon as funds are available and before any facilities listed in Group II, III or IV are developed.

Group II - Planning for these facilities should be done concurrently with the development of services in Group I. Construction should begin after services in Group I have been developed and when funds are available.

Group III - Planning for these facilities should be done concurrently (or sooner) with the construction of facilities in Group II. Construction should begin after facilities in Group II have been completed and when funds are available.

Group IV - Planning for these facilities should be done concurrently (or sooner) with the construction of facilities in Group III. Construction should begin after facilities in Group III have been completed and when funds are available.

It should be noted that although reference is made to development of Home Care/Home Support services only in Group I, the Consultants believe that the highest priority in all areas of the province should be development of comprehensive Home Care and Home Support services for both acute and long term care.

Group I

Location	Services/Facilities to be Developed
Burgeo	Pilot Project - Home Care/Home Support services.
Clarenville	Pilot Project - Home Care/Home Support services.
Fogo	Pilot Project - Home Care/Home Support services.
Harbour Breton, St. Albans	Pilot Project - Home Care/Home Support services.

Group II

Location	Services/Facilities to be Developed
Botwood	New nursing home.
Burgeo	New multi-purpose centre.
Corner Brook	Corner Brook Interfaith - conversion to level II - III.
Fogo	New multi-purpose centre.
Grand Bank	Ambulatory care facility with holding beds.
Grand Falls	Carmelite House - redevelopment.
Harbour Breton, St. Albans	New multi-purpose centre.

Group III

Location	Services/Facilities to be Developed
Bonne Bay	New multi-purpose centre.
Clarenville	New nursing home.
Clarke's Beach	Pentecostal Home - redevelopment.
Placentia	New multi-purpose centre.
St. Anthony	St. Anthony Interfaith Home - expansion.

Group IV

Location	Services/Facilities to be Developed
Brookfield	Ambulatory care facilities.
Port Saunders	New health centre.
Twillingate	Notre Dame Bay Memorial Hospital - expansion of level II - III beds.

Priorities for Development of Level I Facilities

As of January 1986, there were a total of 1007 licensed boarding homes in the province or 20 beds per thousand population aged 65 years and over. In addition are the 282 beds in Waterford homes and 346 level I beds located in nursing homes. In total, therefore, there are 1635 beds providing level I care or 33 beds per thousand population 65 years and over.

Although the total number available for level I care is above the recommended norm of 30 beds per thousand population 65 years and over on a province wide basis, there is a significant maldistribution of these beds with the Avalon Peninsula having a substantial surplus and all other areas having a substantial deficit. This is a serious problem as this level of care should be available as close to home as possible for the residents' quality of life. The result of the maldistribution is that persons in need of this care but not living on the Avalon must either move to the Avalon and compromise community and family ties, remain in their community in inappropriate circumstances or enter a nursing home. In the future, the latter option will be less available as nursing homes become more and more occupied by level II and III residents.

The Bed Study has identified those areas of the province in which there are substantial deficits of level I facilities according to the norm. In most areas the Consultants' recommendations have been conservative and at least in the short run, do not bring these areas up to the full capacity allowed by the norm. Because of the apparent oversupply on the Avalon Peninsula (supported by evidence of a substantial number of vacant beds) and because provision of the recommended home care/home support services is expected to reduce the need for level I beds, it is recommended that no additional beds be licensed in the Avalon district until a detailed study has been completed. In fact, based on current information, the number of beds on the Avalon Peninsula should be reduced.

Newfoundland Bed Study - 8514

The recommended priorities for development of level I facilities are listed below. The priority groupings are as follows:

Group I - Highest Priority - to be provided as soon as funds are available.

Group II - Second Priority - to be provided as soon as all facilities in Group I are provided.

Further subdivisions within the groups (a, b, c, etc.) indicate rank order high to low (i.e. a = highest).

Group	Sub-Group	Location	Number of Beds*
I	a	Central C District	6
		Fogo	6
		Western B District	12
		Bonne Bay area	6
I	b	Western B District	12
		Baie Verte area	6
		Burin Peninsula	6
		Glovertown - Eastport area	6
I	c	Western B District	6
		Bonavista Peninsula	6
		Subtotal, Group I	72
II	a	Western B District	12
		St. Anthony area	6
		Twillingate area	6
		Bonavista Peninsula	6
II	b	Burin Peninsula	6
		Corner Brook	6
		Glovertown - Eastport	6
		Western B	6
		Subtotal, Group II	54

*** The consultants recommended numbers in accordance with the Royal Commission recommendation of limiting the number of beds to be licensed in a facility to a maximum of six. These recommended priorities are based on the understanding that a limited number of beds will be licensed by the province and do not reflect the totals recommended in regional plans. The beds recommended should be located in the general area indicated, but do not necessarily need to be located in the town named or all in one facility (i.e. 2 homes of 3 beds could make up the total of 6).**

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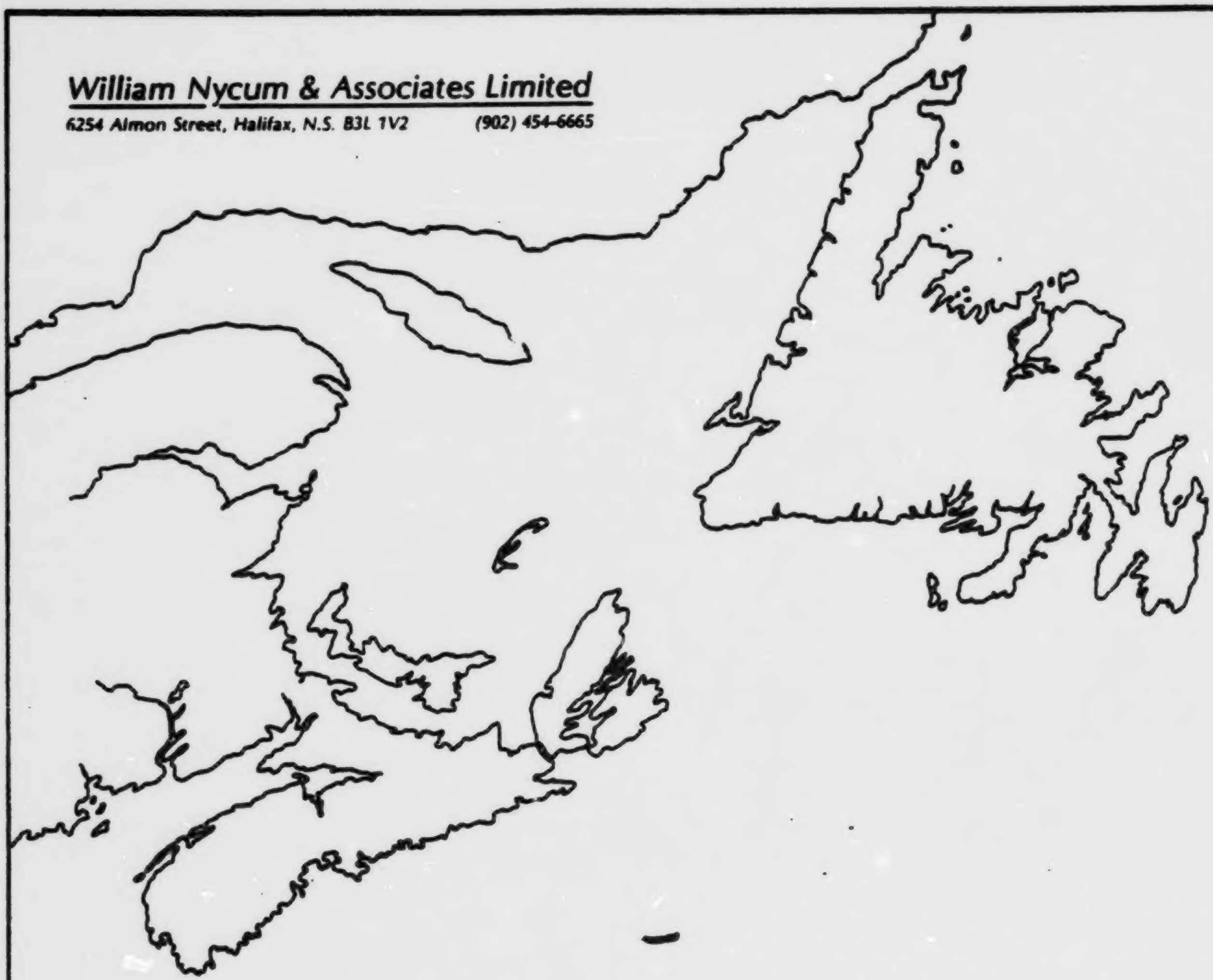

Provincial Bed Study

Department of Health
Newfoundland and Labrador

DEPARTMENT OF HEALTH
Newfoundland & Labrador

PROVINCIAL BED STUDY

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Terms of Reference

Survey Forms:
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Throughout the study, the Consultants received assistance from many persons. We would like to take this opportunity to acknowledge the time and efforts of all those who helped, but in particular, the following groups.

Our special thanks are extended to the Boards and staff of hospitals and nursing homes for the valuable information they provided and for their assistance in arranging meetings and transportation to some of the more isolated communities in the province.

Public Health Nursing staff and the staff of the District Social Services offices are thanked for their time and effort in completing surveys and also for their invaluable input into the regional meetings. The input received from representatives of the medical community, from voluntary agencies and community groups at these meetings, was also extremely valuable to us, particularly in providing us with insight into local conditions which we would otherwise have been unable to obtain.

We would also like to extend our sincere thanks to the Licensed Boarding Home Operators who so willingly opened their doors to us, often on short notice.

Staff of the Department of Health and other Provincial Government Departments were also very helpful in providing us with important background and statistical information.

Finally, we would like to recognize the many hours spent by members of our Advisory Committee in guiding us throughout the study.

William Nycum & Associates Limited

CHAPTER 1
INTRODUCTION

In 1984, the Royal Commission on Hospital and Nursing Home Costs presented its Report to the Government of Newfoundland. The recommendations of the Commission report were endorsed by Cabinet in 1985.

The Commission Report indicated that there is an excess of approximately 350 acute care beds and a deficit of approximately 700 nursing home beds in the province. As well, the Commission recognized that there was a need to expand home care and other community based programs. In response, it was recommended that a detailed provincial bed study be conducted by region and hospital to determine:

(a) in so far as possible, the role and service function of each region and hospital;

(b) the requirement for general hospital beds up to the year 2000 and;

(c) the potential for reduction of existing beds to realize some or all of the savings attributable to the closure of 355 beds (or thereabouts, depending on the impact of the new facilities presently being constructed).

It was further recommended that plans be developed for the construction of 700 additional nursing home beds to accommodate present and future needs of persons requiring high level nursing care.

This study was conducted to address both of these recommendations, and, in addition, to address the requirement for services to meet the needs of those who require primarily supervisory services on an ambulatory basis, often referred to as Level I services. Specifically, this aspect of the study was to determine the number and location of additional licensed boarding home beds required in the province.

The Royal Commission recommended that a maximum of 1185 acute care beds be provided in St. John's. Since the allocation of these beds is the subject of a study being conducted by the St. John's Hospital Council, this study does not provide recommended capacities for the hospitals in St. John's. However, the consultants reviewed data from a number of sources and met with personnel from all hospitals in St. John's regarding the Royal Commissions' recommendations. In addition, the consultants discussed bed numbers with personnel from hospitals outside St. John's. As a result of our studies, we feel that the 1185 acute care beds recommended for St. John's will be more than adequate to meet the needs until 2001.

CHAPTER 2
APPROACH

This study and the recommendations set forth in this report are based upon the assumption that regional self sufficiency in health care delivery is a desirable and achievable goal except for tertiary care provided only in St. John's. In the short to medium term, this goal, as it pertains to acute care, may not be completely attainable in some regions and in some specialties. Self sufficiency in the provision of long term care services however, should be attainable in all regions of the province.

The number of acute care beds required in any region of the province is dependent upon the availability of long term care beds. Similarly, the requirement for institutional beds and services, whether for acute care or long term care is affected by the availability of community based health care and home support services.

In view of this, the consultants have based the regional plans outlined later in this report on the assumption that a major commitment will be made by the Province to develop comprehensive, community based home care and home support services. The recommendations for bed numbers in acute care institutions and even more so, in long term care facilities, reflect this. Therefore, if comprehensive home care/home support services are not developed, there will be a requirement for greater numbers of institutional beds with resultant higher costs in the future.

The consultants accepted the assessment of the Royal Commission that there was an excess of acute care beds in the province. Based upon a review of information from other provinces and of past and projected trends in hospital utilization in Newfoundland and Labrador, the Commission's target norm of 3.5 - 4.0 acute care beds per thousand population was considered appropriate by the consultants for use in this study. It should be noted however, that the consultants refined this norm to reflect the pattern of referral observed in the province, whereby approximately 10% of those requiring acute care are referred to St. John's for tertiary level services. The extent to which this referral pattern will continue should be evaluated in light of expansion of specialty services in the regions. For planning purposes we have assumed that in the short run this pattern will continue. Therefore, the norm applied to the regional populations to determine requirements for acute care beds was 3.15 - 3.60 beds per thousand population.

A further refinement resulted in development of the norm of 1.125 beds per thousand population 0 - 14 for pediatric beds in designated units and a norm of 0.2 beds per thousand population to determine requirements for general rehabilitation beds. The norm for pediatric care is included within the overall norm of 3.5 - 4.0 beds per thousand population for acute care. The guideline for rehabilitation beds is over and above the acute care allotment.

From the outset, the intention was to validate the needs for long term care services rather than accept the norms recommended by the Royal Commission. However all of the information required to do a detailed needs assessment was not available. Based on the information available to the Consultants during the course of the study, the norms of 40 beds per thousand population 65 years and over for level II and III care and 30 beds per thousand population 65 years and over for level I care (as recommended by the Royal Commission) were considered not unrealistic.

It should be noted that in some regions of the province, beds required for either acute or long term care may be higher than that recommended through application of the norms.* Factors such as isolation, problems with transportation, etc. were taken into consideration by the consultants in recommending bed numbers.

Following is a summary of the activities undertaken in an attempt to define needs and to support the bed numbers recommended by application of the formulae discussed above:

1. A review of morbidity and mortality data for Newfoundland and Canada.

2. A review of trends in occupancy levels by size of hospital and type of service within hospitals.

3. An analysis and projection of referral patterns.

*** In order to refine the norms, it is essential that the Province of Newfoundland and Labrador develop a comprehensive information base for acute and long term care. For example, utilization information for ambulatory care services similar to that reported for inpatient services is required. Also a source of comprhensive information such as could be generated through regional assessment and placement services (including functional, social and economic information, etc.) on persons requiring long term care would be extremely useful in determining the "need" for specific services.**

4. A review of population projections by age category.
5. A review of literature on acute and long term care services from many developed countries including Great Britain, U.S.A., The Netherlands, Denmark and West Germany.
6. A review of recent Canadian studies and reports related to long term care needs and services.
7. Visits to most hospitals and nursing homes in Newfoundland and Labrador during which extensive discussions were held with staff.
8. A review of reports and briefs on long term care needs submitted by various groups in Newfoundland and Labrador.
9. A survey of waiting lists* for all nursing homes in the province.
10. A survey of public health nurses, V.O.N., home care programs (where applicable) and district social services offices.
11. Discussions with government officials and selected voluntary agencies.
12. Meetings held in each long term care district** to which were invited health care providers and consumer groups.
13. Visits to selected boarding homes and other related facilities such as Civic # 4.

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* Waiting lists do not necessarily accurately reflect those in "need" of nursing home care.

** The only long term care district in which the consultants did not have a regional meeting was in the Northern Region. The meeting scheduled for this district was canceled due to a blizzard. However, lengthy telephone conversations were held with appropriate individuals to discuss requirements for long term care in the district.

In developing recommendations, the consultants also took into consideration anticipated future trends and a number of factors which are expected to have an important impact on the use of institutional beds and services. These included the following:

1. The effect of anticipated changes in technology and improvements in transportation on the pattern of health care delivery.
2. The extent to which attitudes of health professionals and the public are directed towards prevention of institutionalization.
3. The extent to which financial incentives can and should be used to encourage use of the best and least expensive type of service.
4. The extent to which modifications in lifestyle should affect morbidity.

CHAPTER 3
LIMITATIONS

As previously discussed, the consultants attempted to quantify needs for institutional services. When it became clear that all of the information required to do a detailed needs assessment was not available, the norms recommended by the Royal Commission were adopted for use in this study. However, the consultants obtained information from a number of sources outlined below in an attempt to determine how closely the numbers of beds recommended through application of the norms matched the "need" for services as estimated by Nursing Homes, Public Health Nurses and Social Services personnel.

All Public Health Nurses and Social Services personnel in district offices were surveyed to obtain their estimates of the numbers of persons in need of various services. The responses obtained clearly demonstrated that the question of need is subjective and must be considered within the context of services available and the attitudes of patients and caregivers. For example, for each category of service (Nursing Home, Boarding Home and Home Care), the estimates provided by Public Health Nurses were almost three times higher than those of Social Services personnel. The reason for this discrepancy is unclear, however, it may be speculated that Public Health Nurses (of whom there are a larger number) are more knowledgeable/familiar with the needs of those requiring such services in their areas of responsibility than Social Services personnel.

Nursing Homes in the province were also surveyed to obtain information regarding those on their waiting lists. Areas with large numbers of beds still reported many in need of admission. Furthermore, a review of detailed information provided on the top ten on the waiting lists indicated that many did not appear to need nursing home care at all. It appeared that persons were applying for admission to a nursing home for security reasons (i.e. in case their health deteriorated). The fact that some nursing homes indicated they had to call 10 or 15 persons on the waiting list before they were able to get a placement would appear to confirm this observation.

The consultants were also advised that many people apply simultaneously to a number of nursing homes and that some persons already in nursing homes have their names on the waiting list for other nursing homes. Therefore waiting lists reflect higher numbers of persons in need of nursing homes care than, in fact, there are. Based on the above, it is clear that waiting lists are not an accurate measure of need.

In addition to these general points, there are some specific limitations to this study.

The first of these relates to the limited amount of information available regarding those under 65 years of age who require or may require long term care services. The Royal Commission identified the population requiring long term care as including the elderly, the chronically ill, the chronically disabled, the mentally retarded, the mentally ill and others. Because the majority of those requiring long term care are elderly, the Report concentrated on that population. This report too, concentrates on that population.

The norms of 40 beds per thousand and 30 beds per thousand have been applied to the population 65 years and over to determine beds required for level II - III and level I care respectively. It should be noted however, that those under 65 years of age requiring such care were taken into consideration in the development of the norms. Therefore, the recommendations for bed numbers for levels I, II and III care apply to those under 65 as well as those over 65 years of age who need such care. Because of the limitations of the information available however, the consultants were unable to make specific recommendations regarding special types of services and accommodations such as group homes, which may be required by those under 65 years of age with certain long term health care problems. A detailed information base regarding those with special needs best met in environments other than nursing homes or personal care facilities should be developed and a detailed needs assessment should be carried out in the future.

The second specific limitation relates to difficulty experienced by the consultants in reconciling inconsistencies in statistical information due to the necessity of obtaining data from various sources. For example, information obtained from Hospital Annual Returns frequently differed from that abstracted from the Department of Health Admission and Separation (A & S) System. In addition, bed numbers reported on the Annual Returns were very often different than beds in operation at the time of the consultant visits. Although every effort has been made to maintain internal consistency, there may still be instances where discrepancies exist.

Finally, the consultants have been unable to address, in any detail, the requirement for psychiatric beds and services other than for old age psychiatric services. Since a Provincial plan for psychiatric services has not yet been developed, it is unclear how the issue of institutional, versus community based psychiatric services will be resolved. Therefore, in accordance with the recommendation in the Royal Commission report, the consultants have not recommended any changes in the number of psychiatric beds in the province other than for old age psychiatric services.

CHAPTER 4
DEFINITIONS

Old Age Psychiatric Services - Because of the somewhat negative connotation associated with the term "Psychogeriatric", the term Old Age Psychiatric Services has been used in this document. These are services directed toward meeting the needs of three groups of the elderly population as identified by Dr. H. Strong in his Proposal for an Old Age Psychiatric Service dated August 6, 1984.

The first of these groups are people suffering from functional illnesses but who are often reasonably physically fit. Depression and paranoid states are the two most common conditions. Many suffering from these conditions can be treated as day patients, while some, who require special investigations or treatments, will require inpatient care.

The second group is comprised of persons with organic cerebral illness who are physically mobile and do not have significant problems with incontinence. These persons may be managed in the community with appropriate support or, in the absence of such support, may require long term institutional care.

The third group is comprised of persons with organic cerebral illness who have concommitant disability such as inability to ambulate without assistance or incontinence. These persons are often very old, and have advanced cerebral disease. Their primary need is for good nursing care by those sensitive to their needs, in an appropriate environment.[1]

Levels of Care - For purposes of this report, the consultants have adopted the definitions used by the Department of Health for Levels I, II and III care. These are as follows:

Level I

This level of care is that which is required by a person who may be ambulatory with or without mechanical aids, who may have decreased physical and/or mental faculties, and who requires primarily supervision and/or assistance with activities of daily living.

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[1] Dr. H. Strong, Proposal for Old Age Psychiatry Service, 1984 08 06, P. 4-6.

The care required is assistance with the activities of daily living such as dressing, washing, grooming and bathing, includes a planned program of social and recreational activities, and provides 24 hour a day supervision by assistants working under daily supervision by health professional staff.*

Level II

This level of care is that which is required by a person who may be ambulatory but requires mechanical aids or is independent at wheelchair level.

The basic characteristics and care required of this level of care are similar to those in level I, but recognizes a heavier level of care and/or supervision requiring additional care time. Care in this level can be carried out by a nursing assistant under the supervision of a Registered Nurse as directed by the attending physician.

Level III

This level of care is that which is required by a person who is confined to bed, or can be moved from bed to chair with assistance. All patient care is carried out under continuing medical supervision and all nursing care is carried out by around-the-clock supervision by a Registered Nurse as well as supervision by various other professional health workers, e.g. Dietitian, Social Worker, Physiotherapist or Occupational Therapist.

The care required for this level includes skilled assistance with activities of daily living, such as dressing, washing, grooming, and bathing, a program to assist in retaining or improving the individual's functional ability, daily nursing procedures such as surgical dressings, catheter care, etc. and a fulfillment of social needs.

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* It should be noted that Level I services are provided both in nursing homes and in licensed boarding homes in Newfoundland. Licensed boarding homes frequently do not provide supervision by health professional staff. In the consultants' opinion, supervision by health professional staff is not necessarily required.

In addition to defining these levels of care, the Department of Health applies guidelines for the allocation of hours of care according to the level of care. For example, persons classified as Level I, II or III require 1 hour, 2 hours or 3 hours of care per 24 hour period, respectively. It should be noted that the consultants do not endorse these guidelines as there are many persons classified at each of these levels who require less or (more importantly for staffing) more than the hours of care discussed above. Therefore, when discussing levels of care throughout this report, the consultants are referring only to the type of care required. Staffing should be based on the acuity of the individual patient and the services required to meet that particular individual's needs.

Special Rehabilitation - The term "special" rehabilitation refers to patients requiring admission to a center where highly specialized physical and human resources, (i.e. physiatrists, occupational therapists, physiotherapists, speech language pathologists, etc.) are available to provide intensive therapy aimed at restoring the maximum level of functioning. The types of cases admitted to special rehabilitation units include new spinal cord injuries, brain damaged persons with high recovery potential, new amputees and very selected strokes (i.e. young, high potential).

General Rehabilitation - General rehabilitation, in the context of this report, refers to a slower paced, less "high tech" type of rehabilitation for persons with neurological disorders (e.g. multiple sclerosis), elderly amputees, stroke victims, etc. These services, in other provinces, are provided in regional hospitals with specialty staff, but not necessarily under the direction of a physiatrist.

Personal Care Facilities - This term has been used throughout the report to define facilities appropriate for the delivery of level I services and includes licensed boarding homes, congregate living facilities and foster homes. In institutions not well designed for levels II and III care and in areas where there is excess capacity in nursing homes, it may be appropriate to provide level I care in nursing homes. However, in the consultants judgment, this is not the ideal environment for such care.

Congregate Living Facilities - These facilities are group housing arrangements in which private living quarters are combined with some shared spaces such as kitchen and dining facilities. In instances where level I services are provided in such facilities, supervision is provided on a 24-hour basis.

Long Term Care - The Royal Commission defined the elderly as those people aged 65 and over, and long term health care, as "the personal services required on a recurring and continuous basis by an individual because of chronic or permanent physical or mental impairment."

Planners define long term care services as a continuum of interrelated health and social services. These services encompass both institutional and non-institutional services and require co-ordination of public policies, funding and case management to provide appropriate options for service to individuals whose needs change over time.

The definition of long term care within which this study has been conducted is the one put forth by the American College of Physicians in their Position Paper on Long Term Care as follows:

"Long term care refers to the medical and support services needed to attain an optimal level of physical, social and psychological functioning by persons who are frail and dependent due to chronic physical or mental impairments. It includes services to prevent avoidable deterioration of health, to treat acute exacerbations of chronic illness, to maintain the maximum possible independence, and to restore the individual to the optimal level of functioning that can be sustained."

Long term care, therefore, refers to a continuum of interrelated health and social services and includes much more than nursing home beds; it includes access to acute and rehabilitation beds and services, diagnostic services, respite care, day care, home care and home support services, dental care, vision and hearing care, foot care, etc.

CHAPTER 5
DEMOGRAPHICS

The Royal Commission discussed the impact of changing population patterns on the past and anticipated future use of health care services. Therefore we need only emphasize the following major points concerning changes in the population of Newfoundland and Labrador.

- The population aged 0 - 14 has declined in the past decade and is expected to continue to decline in future. The projected greatest declines (on a percentage basis) are in the Central and Western regions.

- From the standpoint of planning health services, the most significant demographic factor will be the increasing population aged 65 and over. Between 1971 and 2001 the population in this age group is predicted to double. This growth affects all regions of the province. It should be noted, however, that this predicted growth represents an increase of only slightly more than 22,000 "seniors" between 1981 and 2001. The population aged 75+ represents an even greater expansion on a percentage basis (i.e. a doubling between 1981 and 2001) but still represents only 28,706 people or 4.8% of the total population by 2001.

Table 5.1

Historical and Projected Population by Region
Newfoundland and Labrador

All Ages

Region	1971	1981	Projected	
			1991	2001
St. John's	128,090	136,742	149,006	152,093
Avalon	82,895	98,935	105,657	103,634
Burin-Bonavista	55,105	61,520	64,960	66,977
Central	117,565	124,045	126,547	129,898
Western	93,455	96,570	97,882	100,542
Northern	16,900	18,855	20,598	19,676
Labrador	28,145	31,315	30,394	29,211
Newfoundland Total	522,155	567,982	595,044	602,031

Population Aged 0 - 14

Region	1971	1981	Projected	
			1991	2001
St. John's	41,855	36,230	32,076	31,139
Avalon	30,410	28,090	26,183	21,302
Burin-Bonavista	19,780	18,800	16,599	15,375
Central	47,020	38,230	31,131	26,329
Western	37,430	29,070	24,237	20,108
Northern	7,040	6,040	5,313	4,701
Labrador	11,475	10,940	8,749	6,913
Newfoundland Total	195,010	167,400	144,288	125,867

Note: Projections for 1991 and 2001 are from data provided for Royal Commission

Population Aged 65 +

Region	1971	1981	Projected 1991	Projected 2001
St. John's	8,475	10,818	14,278	16,559
Avalon	6,940	9,055	11,983	13,784
Burin-Bonavista	4,085	5,665	7,555	8,675
Central	6,795	9,500	12,594	14,486
Western	4,610	6,215	8,185	9,151
Northern	770	1,070	1,418	1,611
Labrador	535	670	893	1,032
Newfoundland Total	32,210	42,993	56,906	65,298

Population Aged 75 +

Region		1981	Projected 1991	Projected 2001
St. John's		2,910	5,816	7,465
Avalon		1,131	4,735	5,978
Burin-Bonavista		2,015	3,160	3,944
Central		3,331	5,055	6,365
Western		2,145	3,230	3,800
Northern		355	547	675
Labrador		230	379	479
Newfoundland Total		14,207	22,922	28,706

CHAPTER 6
HEALTH STATUS INDICATORS

The Department of Health of Newfoundland and Labrador has recently completed a draft paper on the health status of the people of Newfoundland and Labrador. Some of the information in the paper has a direct impact on utilization of hospital beds, while some indicators have a more subtle effect on utilization of beds. Following is a summary of some of the information highlighted in the paper:

- Between 1960 and 1983, Newfoundlanders had a lower standardized death rate for cancer of the trachea, bronchus and lung, although by 1983 the rate for Newfoundland males converged and passed the Canadian average.

- In the same 23 year period death rates for breast cancer were lower for Newfoundland women than the Canadian average and higher than the Canadian average for cancer of the cervix.

- Death rates for ischemic heart disease have been declining for both sexes in Canada and Newfoundland follows a similar trend. Death rates for cerebrovascular disease have been higher for both males and females in Newfoundland than the Canadian average but rates have been declining faster in Newfoundland than in Canada so that Newfoundland is now approaching the Canadian rates.

- Death rates for chronic obstructive lung disease have been lower for Newfoundland males than the Canadian average and similar to the Canadian average for Newfoundland females.

- Dental health of Newfoundland children is poorer than that of Ontario and Alberta children, with the Northern region (including Labrador) reporting the poorest dental health of the five public health regions.

- Infant mortality in Newfoundland was traditionally higher than the Canadian average but has been falling at a faster rate so that it is now similar to the Canadian average.

- Newfoundland had a low percentage of infants ever breast fed, less than half that of Canada. Rates for Northern (including Labrador), Eastern and Central were lowest, while rates in St. John's and Western were highest.

- Although on average, Newfoundland and Canada are similar in selected natality statistics (e.g. low birthweight ratio) in others there are differences (e.g. births to teenage mothers and illegitimacy rates). In addition, some of these rates vary significantly between regions of the province. For example:
  - The percentage of births to mothers under 20 years of age is 7.3% for Canada (1983) but 15.3% for Newfoundland. Within Newfoundland the rate varied from a low of 3.7% for St. John's to a high of 19.5% for the Northern Region (including Labrador).
  - The illegitimacy ratio for Canada was 16.0, but 20.9 for Newfoundland as a whole. This rate varied from a low of 14.6 in St. John's to a high of 33.7 for Northern (including Labrador). (See Table 6.1). The therapeutic abortion rate in Newfoundland is substantially lower than the Canadian average. (See Table 6.2).

Overall, in terms of health status factors that affect hospitalization rates, Newfoundland does not vary significantly from the rest of Canada. Therefore, use of bed to population norms similar to those in use in other Canadian provinces would not seem unrealistic. Disease trends which will impact on hospital utilization in future include the following:

1. Death rates for cerebrovascular disease have declined in both Newfoundland and Canada and are expected to continue to decline. These declines are undoubtedly due to aggressive efforts to treat hypertension.
2. Death rates for ischemic heart disease have been declining and are expected to continue to decline. In the short to mid term, this may lead to more requirements for care of survivors but in the long run, declines in care requirements could be anticipated.
3. Based upon discussions with hospital and nursing home personnel, diabetes is considered to be a major health problem in Newfoundland. Precise numbers are difficult to obtain because there is no central registry and cause of death is usually reported as another cause. Improved diagnosis and control of diabetes will lead to reductions in complications such as cardiovascular disease, cerebrovascular disease, ophthalmological problems, etc.

4. The incidence of hypertension has been considered high in Newfoundland, and it appears to be higher than average in coastal Newfoundland. Many areas seem to be controlling hypertension through good physician management, while in other areas the degree of compliance is still less than optimal. Lifestyle modification can play a significant role in alleviating this problem. Efforts to encourage this should be promoted so that admissions to hospital for hypertension related disorders can be reduced.

5. Cancer of the trachea, bronchus and lung has been increasing in both Newfoundland and Canada, particularly among women. These rates are expected to continue to rise at least for the next decade. Newfoundland has the fastest rate of increase for lung cancer in Canada and based on current age standardized trends, will be either the first or second leading province for lung cancer by 1990.

Table 6.0

COMPARISON OF AGE STANDARIZED MORTALITY RATES
NEWFOUNDLAND & CANADA 1973 - 1979
SELECTED CAUSES OF DEATH

Cause	Canada		Newfoundland	
	M	F	M	F
All Causes, all ages	881.6	504.4	856.4	515.9
Coronary Heart Disease, ages 35-69	367.5	105.8	372.3	125.7
All Cancer Sites, ages 35-69	258.9	198.2	265.4	183.9
Lung Cancer, ages 35-69	92.7	22.8	83.6	12.0
Chronic Obstructive Lung Disease, ages 35-69	32.3	10.0	28.9	9.1
Cirrhosis of Liver, ages 35-69	39.6	15.6	15.3	5.9
Motor Vehicle Accidents, ages 15-35	59.7	16.5	35.0	11.3
Infant Mortality *	13.3		15.1	

* Rate per thousand livebirths for both sexes ages less than one year.

Source: Statistics Canada: Mortality Atlas of Canada

Table 6.1

SELECTED NATILITY INDICATORS
NEWFOUNDLAND & LABRADOR
1983

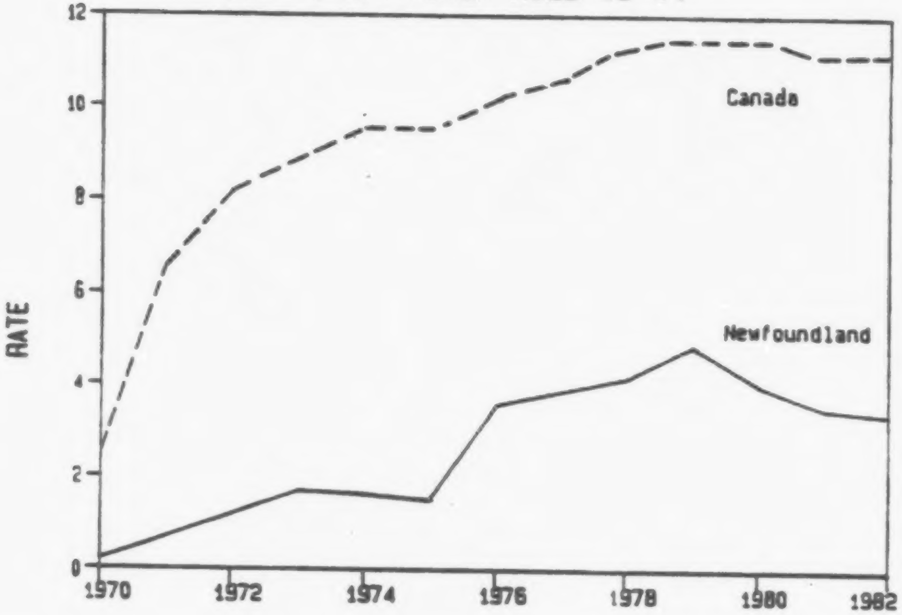
			Health Region				
	Nfld	Canada	St. John's	Eastern	Central	Western	Labrador/ Northern
% of Births to Mothers <20 years	15.3	7.3	8.7	14.9	14.0	17.5	19.5
Illegitimacy Ratio	20.9	16.0	14.6	15.9	23.0	28.5	33.7

Source: Department of Health, Newfoundland and Labrador

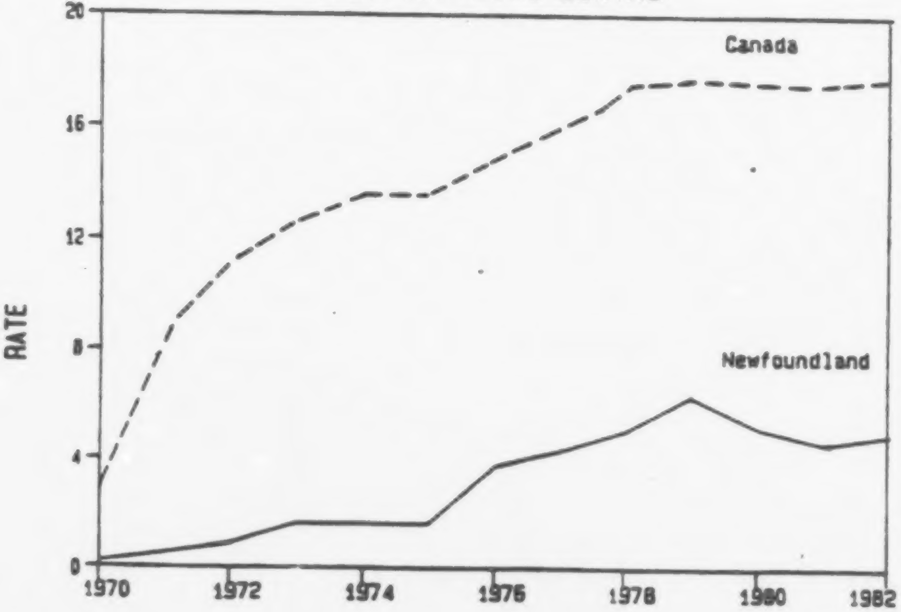
Table 6.2

Therapeutic Abortion Rates
1970-1982

PER 1,000 WOMEN AGED 15-44



PER 100 LIVE BIHTHS



Source: Department of Health, Newfoundland & Labrador

CHAPTER 7
HOSPITAL UTILIZATION

This chapter discusses comparative hospital utilization information for Newfoundland and Canada and for regions within Newfoundland and Labrador. Unfortunately, due to a lack of information systems, similar comparisons could not be made for nursing home utilization.

Comparisons, Newfoundland and Canada

Table 7.1 provides a comparison of certain hospital inpatient utilization rates for Newfoundland and Canada. Following are some comments on this table.

- In total (all diagnoses), the separation rates per 100,000 population are higher for Newfoundland than Canada for both males and females. However, average length of stay is significantly lower than the Canadian average with the result that in terms of days/100,000 population, Newfoundlanders are lower utilizers than the Canadian average.
- The separation rate for infectious and parasitic diseases for Newfoundland is very high compared to the Canadian average but lengths of stay are shorter. Since the majority of hospitalizations in this group occur in the pediatric (0 - 14) population, this rate could be affected by the following factors:
  - a higher proportion of young people in the Newfoundland population
  - proportionately fewer pediatricians in Newfoundland than in Canada as a whole
  - traditional patterns of practice in Newfoundland and an over abundance of pediatric beds which encourage admission
  - a higher incidence of such diseases in the Newfoundland population (we have, however, found no evidence to substantiate this)
- Separation rates and average length of stay for neoplasms are lower than the Canadian average. This pattern is consistent with the fact that Newfoundland had a lower death rate from all types of cancer between 1960 and 1983.

Table 7.1

COMPARISON OF SEPARATION RATES BY CANADIAN DIAGNOSTIC LIST, CANADA & NEWFOUNDLAND 1980/81

Diagnostic Group	Seps/100,000 Pop.				Average Stay			
	Canada		Nfld		Canada		Nfld	
	M	F	M	F	M	F	M	F
Infectious & Parasitic Dis.	202	195	340	337	11.2	9.8	7.2	5.9
Neoplasms	818	999	694	833	17.6	15.2	15.3	13.9
Endocrine, Nutritional & Metabolic Diseases	224	325	289	527	16.6	17.0	11.5	10.1
Diseases of the Blood & Blood Forming Organs	89	106	127	136	9.8	12.2	7.5	10.7
Mental Disorders	621	706	634	791	22.7	26.5	15.7	16.5
Diseases of Nervous System & Sense Organs	633	675	613	621	17.4	19.1	10.1	11.0
Diseases of the Circulatory System	1818	1436	1700	1509	20.3	29.6	12.3	13.6
Diseases of the Respiratory System	1720	1369	2187	1804	8.1	7.7	6.1	6.1
Diseases of the Digestive System	1844	1692	1749	1720	7.8	8.9	7.7	7.4
Diseases of the Genito-urinary System	807	1669	966	2482	8.7	6.4	8.1	5.9
Complications of Pregnancy, Childbirth & Peuperium	-	4219	-	4872	-	4.8	-	6.0

Table 7.1 (con't)

COMPARISON OF SEPARATION RATES BY CANADIAN DIAGNOSTIC LIST, CANADA & NEWFOUNDLAND 1980/81

Diagnosis	Seps/100,000 Pop.				Average Stay			
	Canada		Nfld		Canada		Nfld	
	M	F	M	F	M	F	M	F
Diseases of Skin & Sub-cutaneous Tissue	213	219	320	309	9.6	9.4	9.1	10.2
Diseases of Musculoskeletal System & Connecting Tissue	740	766	634	633	10.1	14.8	8.9	10.6
Congenital Anomalies	176	140	265	194	9.7	10.9	15.2	13.8
Certain Conditions Originating in Perinatal Period	45	33	48	37	14.5	15.4	17.8	21.9
Symptoms, Signs & Ill Defined Conditions	695	763	630	875	8.6	10.1	6.0	5.6
Injury & Poisoning	1590	1063	1585	1065	9.1	12.9	8.3	9.6
Supplementary Classifications	302	671	301	800	13.7	10.5	9.0	4.7
Total, All Diagnoses	12537	17046	13082	19545	12.4	11.7	9.3	8.2

Days/100,000 population:					
Canada	M	155,141	Newfoundland	M	121,944
	F	198,638		F	160,888

Source: Hospital Morbidity, Statistics Canada Catalogue 82 - 206

- Separation rates for endocrine, nutritional and metabolic diseases (of which the majority is for diabetes) are substantially higher for Newfoundland (particularly females) than for Canada. Average length of stay is, however, lower for Newfoundland. These figures suggest there is room for reduction in the Newfoundland rate through prevention and education programs.

- Separation rates for diseases of the circulatory system were lower for Newfoundland males and higher for Newfoundland females than Canadian averages, but average length of stay was substantially lower for both males and females in Newfoundland. Because these diseases primarily affect the elderly, the rates may be influenced by the fact that Newfoundland has a young population relative to the rest of Canada.

- The separation rates for diseases of the respiratory system are higher than Canadian averages for both males and females. Average lengths of stay are lower for Newfoundland. Respiratory diseases affect primarily the very young (under age 2) and the elderly, and therefore part of this rate may be influenced by the same factors discussed under infectious diseases for the pediatric population. The age standardized mortality rates for chronic obstructive lung disease are slightly lower than the Canadian average for both males and females in Newfoundland. The reason for the differences between Newfoundland and Canada should be explored.

- Separations for diseases of the genitourinary system are high for both males and females in Newfoundland compared to the Canadian average, while lengths of stay are slightly lower for Newfoundland. The reason for the large variation in rates for females requires further exploration.

- The separation rate for Newfoundland for complications of pregnancy is higher than the Canadian average. This is probably explained by the higher fertility rate and younger population in Newfoundland. Average length of stay for Newfoundland is longer, however. This fact may be partially explained by geography in that expectant mothers are hospitalized prior to delivery when they come from outlying areas. However, this factor probably does not account for the entire difference.

- Separation rates for diseases of the skin and subcutaneous tissue are higher for Newfoundland than for Canada. Average length of stay is lower for males and higher for females in Newfoundland than Canada.

- Rates for diseases of the musculoskeletal system and connective tissue are lower for all indicators for Newfoundland than for Canada. The difference may be partly due to the relatively younger population in Newfoundland since the lower rates are reflected throughout the group including arthritis, rheumatism, etc., whereas Newfoundland rates are actually higher for "intervertebral disc disorders" which affect all age groups.

- Separation rates and average length of stay for congenital anomalies are higher for Newfoundland than for Canada. This may reflect a higher prevalence of such anomalies in Newfoundland. The rates for all individual anomalies listed (i.e. spina bifida, all other congenital anomalies of nervous system, congenital anomalies of heart and circulatory system, cleft palate and cleft lip, other congenital anomalies of digestive system, congenital anomalies of genitourinary system, congenital anomalies of musculoskeletal system) were higher for Newfoundland than for Canada. Higher average length of stay than the Canadian average for both sexes may be influenced by geographic factors. The extent to which the separation rates reflect higher prevalence rates are not known, although spina bifida and cleft palate and/or lip are known to be of higher than average incidence in Newfoundland and Labrador.

- In total, because of shorter lengths of stay, Newfoundlanders used hospital days at a substantially lower rate than the Canadian average - 79% for males and 81% for females. In fact, the Newfoundland days/100,000 population were the lowest of any province.

Table 7.2 provides a comparison of Newfoundland and Canada patient days per 100,000 population for 1980/81 by broad age groups. Note that the rates for Newfoundland in all under 65 groups are substantially higher than Canadian averages, while in the over 65 group they are lower and very substantially lower, in particular, for the 75+ age group.

Since patient days are affected by the availability of facilities, it may not be possible to draw clear conclusions from these rates. Many provinces include chronic, convalescent and rehabilitation beds in general hospitals, whereas such beds are scarce in Newfoundland. These rates should, however, suggest that for the under 65 groups, substantial reductions in utilization rates are required just to reach the Canadian average.

TABLE 7.2

GENERAL AND ALLIED SPECIAL HOSPITALS PATIENT DAYS PER 100,000 POPULATION BY AGE, CANADA AND NEWFOUNDLAND (1980-81)

Age	Canada	Newfoundland
0-14	51,043	71,601
15-44	86,262	129,693
45-64	202,446	247,007
65-74	525,144	484,656
75 +	1,486,811	865,887
Total	176,875	167,080

Historical Trends*, Newfoundland and Labrador

Table 7.3 shows historical utilization rates by age group in Newfoundland and Labrador.

The trend has been toward declining utilization rates in both separations and days for the under age 45 groups, a slight increase in the separation rate for the 45 - 64 age group, a decrease in the days stayed rate due to a declining average length of stay for this group, but increases in separation and day rates for the 65 + group. Average length of stay has declined for all age groups. Therefore, the increase in utilization rates by elderly patients is due to substantial increases in the separation rate and not to longer lengths of stay.

Increases in utilization rates can be attributed to a number of factors which include better access to services, more active intervention in chronic diseases, declining mortality rates, changing morbidity patterns, availability of beds, technology, availability of health manpower, etc. Major proportions of hospital days now result from chronic diseases (heart, respiratory, cancer, etc.).

* For a more detailed overview, refer to Chpater 2 of the Report of the Royal Commission Report on Hospital and Nursing Home Costs.

Table 7.3

NEWFOUNDLAND AND LABRADOR
AGE SPECIFIC UTILIZATION
1971 - 1983/84

0-14 Age Group	1971	1976	1981/82	1982/83	1983/84
Population	194,500	187,800	165,080	163,296	160,884
% of Population	37.3	33.7	28.7	28.5	27.9
% of Hospital Seps.	27.7	23.9	18.9	18.8	18.0
% Hospital Days Stay	22.4	18.2	13.5	13.2	12.8
Sep. Rate/1,000	118	116	100	105	98
Days Stay Rate/1,000	938	768	600	623	618
Length of Stay	8.0	6.6	6.0	6.0	6.3
15-44 Age Group					
Population	215,700	249,100	280,707	275,760	278,440
% of Population	41.3	44.7	48.9	48.0	48.2
% of Hospital Seps.	46.5	45.9	45.4	44.8	44.4
% Hospital Days Stay	36.2	35.0	33.9	32.4	32.3
Sep. Rate/1,000	178	168	141	148	139
Days Stay Rate/1,000	1,365	1,114	889	905	1,000
Length of Stay	7.7	6.6	6.3	6.1	6.5
45-64 Age Group					
Population	79,500	84,800	82,652	88,548	89,822
% of Population	15.2	15.1	14.4	15.4	15.6
% of Hospital Seps.	16.0	17.2	18.1	17.9	18.2
% Hospital Days Stay	23.0	23.0	21.8	21.2	20.9
Sep. Rate/1,000	166	185	191	185	176
Days Stay Rate/1,000	2,354	21,457	1,938	1,846	1,810
Length of Stay	14.2	11.6	10.2	10.0	10.3
65-74 Age Group					
Population	19,900	23,200	29,844	29,980	30,920
% of Population	3.8	4.2	5.2	5.2	5.4
% of Hospital Seps.	5.7	7.3	9.7	10.2	10.7
% Hospital Days Stay	9.9	11.9	15.1	15.8	16.4
Sep. Rate/1,000	237	286	283	356	301
Days Stay Rate/1,000	4,054	4,073	3,734	4,640	4,153
Length of Stay	17.1	14.2	13.2	13.0	13.8

Table 7.3 (con't)

75-84 Age Group	1971	1976	1981/82	1982/83	1983/84
Population	9,800	10,700	12,771	12,900	13,500
% of Population	1.9	1.9	2.2	2.2	2.3
% of Hospital Seps.	3.4	4.5	6.0	6.2	6.6
% Hospital Days Stay	6.7	9.5	11.2	12.3	12.3
Sep. Rate/1,000	285	386	409	440	424
Days Stay Rate/1,000	5,581	7,043	6,473	7,345	7,070
Length of Stay	19.6	18.2	15.8	16.7	16.7
85+ Age Group					
Population	2,300	2,700	3,415	3,500	3,600
% of Population	0.4	0.5	0.6	0.6	0.6
% of Hospital Seps.	0.8	1.2	1.8	2.0	2.2
% Hospital Days Stay	1.8	2.4	4.5	5.1	5.3
Sep. Rate/1,000	283	393	468	527	522
Days Stay Rate/1,000	6,513	6,905	9,674	11,213	11,525
Length of Stay	23.0	17.6	20.7	21.3	22.1
Total Population	522,100	557,800	574,469	573,924	577,086
Total Separations	82,636	91,134	86,980	91,154	87,048
Total Patient Days	814,333	791,985	735,947	770,286	778,483
Length of Stay	10.1	8.7	8.5	8.5	8.9
Total Separation Rate	158	163	151	159	151
Total Pat. Day Stay Rate	1,560	1,420	1,281	1,344	1,349

Exclusions: The data excludes separations from Waterford, Children's Rehab., St. Luke's, St. Pat's, St. John's Sanitorium, (1971 data only), Out-of-Province, unknown origin, and newborns.

Note: Populations do not add due to rounding.

Source: Hospital Morbidity File, Newfoundland & Labrador Department of Health

Diagnostic Groups

Table 7.4 shows separations and average stay by diagnostic chapter for residents of Newfoundland hospitalized during 1972, 1976 and 1983/84. Following are some comments on this table.

- Separations for infectious and parasitic diseases declined by approximately 50%, although average stay remained relatively constant.

- Separations for neoplasms increased while average length of stay decreased. The increases in separation rates are probably due partly to improved survival rates and more aggressive treatment, while the reduction in average length of stay is partly explained by better therapies, allowing shorter lengths of stay.

- Separations for endocrine, nutritional and metabolic disorders (which includes diabetes) have increased but lengths of stay have decreased.

- Separations for diseases of the circulatory system have increased substantially, and length of stay has declined. The reason for the increase in separations may be partly due to an aging population and increased survival rates, but part of the increase must also be due to patterns of practice.

- Diseases of the respiratory system have declined in separations but remained relatively steady in average stay. A large part of the reduction is undoubtedly due to the decline in pediatric utilization for this diagnostic group.

- Separations for diseases of the digestive and genitourinary systems increased in number and declined in average stay. While some of the increases may be due to an aging population, patterns of practice and referral probably also contribute to these changes.

- In 1972, the four chapters - Circulatory, Respiratory, Digestive and Genitourinary System diseases accounted for 51% of all separations (excluding complications of pregnancy). This proportion remained almost unchanged at 50% in 1983/84.

Table 7.4

SEPARATIONS & AVERAGE LENGTH OF STAY BY DIAGNOSTIC CHAPTER
1972, 1976 & 1983/84
ALL AGES, PROVINCIAL TOTAL

ICD Chapter		1972		1976		1983/84	
		Seps	Av. Stay	Seps	Av. Stay	Seps	Av. Stay
I	Infectious & Parasitic Dis.	2679	7.1	2931	7.4	1425	7.2
II	Neoplasms	3325	18.5	4136	15.1	4262	14.7
III	Endocrine, Nutritional Metabolic Dis. & Immun. Dis.	1692	17.6	2062	11.3	2254	11.6
IV	Diseases of Blood & Blood Forming Organs	728	11.6	647	9.7	551	8.3
V	Mental Disorders	3058	13.7	3899	14.1	3477	18.5
VI	Diseases of Nervous System & Sense Organs	3139	10.3	3484	8.7	3218	9.0
	Diseases of Ear & Mastoid Process	1265	7.7	1493	5.9	1086	5.5
	Diseases of Eye & Adnexa	996	9.3	1003	8.3	1078	6.6
VII	Dis. of Circulatory System	6279	15.6	7592	13.4	9180	12.7
VIII	Dis. of Respiratory System	12802	6.7	12640	6.0	9333	6.8
IX	Dis. of Digestive System	7082	10.6	7727	8.7	9468	7.5
X	Dis. of Genitourinary System	7437	8.6	8105	7.4	8893	6.5
XI	Complications in Pregnancy	17144	5.7	15631	5.6	13110	5.9

Table 7.4 (con't)

ICD Chapter	1972		1976		1983/84	
	Seps	Av. Stay	Seps	Av. Stay	Seps	Av. Stay
XII Dis. of Skin & Subcut. Tissue	1817	10.6	1785	9.4	1552	9.8
XVII Dis. of Musculoskeletal Sys. & Conn. Tissue	2128	14.0	3038	11.6	3494	10.4
XIV Congenital Anomalies	1118	18.1	1290	13.7	1005	12.5
XV Certain Conditions Orig. Perinatal Period	148	16.9	260	15.9	254	22.2
XVI Symptoms, Signs & Ill-Defined Conditions	2683	5.2	3754	5.2	4789	4.8
XVII Injury & Poisoning	7471	9.5	7882	8.8	7188	9.5
XVIII,XIX Others	1770	10.8	3002	6.6	3579	8.4
Total, All Diag. (excl. Obs) (incl. Obs)	65356 82500		74234 89865		73922 87032	

Source: Hospital Morbidity file, Newfoundland & Labrador Department of Health

Tables 7.5 and 7.6 compare utilization rates for the four largest non-obstetrical diagnostic chapters by region for 1983/84. Following are some comments on this table:

- In all four categories, the length of stay for residents of St. John's is higher than the provincial average. This is somewhat surprising in view of high occupancy rates and pressures to empty beds that are reported by the St. John's hospitals. However, separation rates are lower for St. John's than for the province as a whole in each grouping and the St. John's hospitals might therefore argue that length of stay reflected complexity since less complicated cases are not admitted to hospital. However, in terms of total days per 10,000 population, residents of St. John's and Avalon are still the highest for diseases of the circulatory system. In the other three groups, residents of St. John's are below the provincial average.
- For respiratory diseases, St. John's is substantially lower than other regions in both separations and days per 10,000 population. This may be strongly affected by pediatric utilization rates as discussed elsewhere.
- The reason for such high separations and days per 10,000 population for digestive disorders in Northern Region is not understood. There may be some effect from pediatric utilization patterns, but this would not entirely explain the difference. This may reflect physician practice patterns.
- For diseases of the genitourinary system, Northern Region has a separation and days per 10,000 rate almost twice that of St. John's. The reason for this requires further exploration.
- It is not possible at present to fully explain the reasons for variations in rates from region to region. The information is presented to stimulate further discussion and to suggest that simply by moderating practice patterns there is probably significant room for reduction in beds used by these major disease groups.

Inter-Region Referral

Table 7.7 summarizes place of hospitalization by region for residents of Newfoundland and Labrador for the years 1978/79 through 1983/84. Throughout the time period shown, there has been very little change in referral patterns between regions except for a slight increase in the percentage of patients from all regions who were hospitalized in St. John's.

Table 7.5

UTILIZATION RATES, SELECTED DIAGNOSTIC CHAPTERS
BY REGION OF RESIDENCE
1983/84

Diagnostic Chapter

Region of Residence	Circulatory System		Respiratory System		Digestive System		Genitourinary System	
	Seps/10,000	Av. Stay	Seps/10,000	Av. Stay	Seps/10,000	Av. Stay	Seps/10,000	Av. Stay
St. John's	153	14.6	116	6.9	136	9.0	115	7.5
Avalon	189	12.1	159	7.2	158	8.3	154	6.2
Burin/Bonavista	184	9.4	203	5.5	170	6.7	155	5.6
Central	168	13.0	178	6.9	182	6.6	192	5.8
Western	146	13.4	172	7.8	168	7.4	154	7.0
Northern	166	10.2	214	6.4	255	6.8	212	7.7
Labrador	94	12.5	223	6.1	208	6.8	187	6.1
Provincial Total	162	12.7	164	6.8	167	7.5	157	6.5

Source: Hospital Morbidity file, Newfoundland & Labrador Department of Health

Table 7.6

UTILIZATION RATES SELECTED DIAGNOSTIC CHAPTERS
BY REGION OF RESIDENCE 1983/84
DAYS/10,000 POPULATION

Region of Residence	Circulatory System Days/10,000	Respiratory System Days/10,000	Digestive System Days/10,000	Genitourinary System Days/10,000
St. John's	2234	800	1224	874
Avalon	2287	1145	1311	955
Burin/Bonavista	1730	1117	1139	868
Central	2184	1228	1201	1114
Western	1956	1342	1243	1078
Northern	1693	1370	1734	1632
Labrador	1175	1360	1414	1141
Prov. Total	2057	1115	1253	1021

Source: Hospital Morbidity file, Newfoundland & Labrador
Department of Health

Table 7.7

REFERRALS BY PLACE OF RESIDENCE & PLACE OF HOSPITALIZATION (INCLUDING NEWBORNS)
1978/79 - 1983/84

Region of Residence	Region of Hospitalization	1978/79		1980/81		1981/82		1983/84	
		No.	%	No.	%	No.	%	No.	%
Eastern	Eastern	47405	97.8	48733	98.0	45181	98.0	47520	98.9
	Others		2.2		2.0		2.0		1.1
	Total	48461		49743		46093		48063	
Central	Central	21830	88.2	21243	86.0	20016	86.8	20759	87.0
	Eastern	2391	9.7	2764	11.2	2483	10.8	2674	11.2
	Others		2.1		2.8		2.4	438	1.8
	Total	24738		24687		23049		23871	
Western	Western	15904	91.4	14696	89.8	14270	90.4	14589	91.0
	Eastern	1040	6.0	1149	7.0	1009	6.4	1250	7.8
	Others		2.6		3.2		3.2	198	1.2
	Total	17402		16374		15783		16037	
Nothern (incl. Labrador)	Northern	10401	86.8	10394	86.4	10173	86.5	9175	87.8
	Western	483	4.0	397	3.3	399	3.4	322	3.1
	Eastern	695	5.8	840	7.0	855	7.3	849	8.1
	Others		3.4		3.3		2.8	102	1.0
	Total	11988		12024		11764		10448	

Source: Hospital Morbidity file, Newfoundland & Labrador Department of Health

Table 7.8

HOSPITALIZATION, RESIDENTS OF NEWFOUNDLAND & LABRADOR POPULATION AGED 65+, SELECTED DIAGNOSTIC GROUPS 1972 & 1983/84

Diagnostic Group	Separations		Rate/1000 pop.	
	1972	1983/84	1972	1983/84
Othr Forms of Heart Dis., Ischem Heart Dis., Acute Myocard.	1581	3092	47.5	67.5
Pneumonia	402	542	12.1	11.8
Other & Late Effects of Cerebrovascular Disease	333	686	10.0	15.0
Symptoms, Senility and Ill-defined Conditions	189	696	5.7	15.2
Diabetes Mellitus	311	650	9.3	14.2
Other Diseases of Urinary System	182	472	5.5	10.3
Bronch., Emphy., Other COPD & Other Dis. of Resp. System	348	1069	10.5	23.4
Other Diseases of Arteries, Arterioles and Capillaries	113	277	3.4	6.1
Cholelithiasis	175	281	5.3	6.1
Cataract	165	264	5.0	5.8

Population: 1972 - 33288
1983/84 - 45775

Source: Hospital Mobidity File, Newfoundland & Labrador Department of Health

Table 7.9

65+ SEPS & DAYS, SELECTED DIAGNOSES (TOP 10 BY DAYS STAYED 65+)
1983/84

Diagnoses	Total		Average Stay	65 +		Average Stay	65 + as % of Total	
	Seps	Days		Seps	Days		Seps	Days
Other Forms of Heart Disease	1928	22098	11.5	1306	16431	12.6	67.7	74.4
All Other Forms of Heart Disease	2471	21781	8.8	1106	11329	10.2	44.8	52.0
Other & Late Effect of Cerebrovascular Disease	907	25205	27.8	686	20674	30.1	75.6	82.0
Acute Myocardial Infarction	1256	16678	13.1	680	9329	13.7	54.1	55.9
Diabetes Mellitus	1540	19067	12.4	650	10547	16.2	42.2	55.3
Fractures of Femur	485	15429	31.8	310	10971	35.4	63.9	71.1
Other Reasons for Contact with Health Services	1119	15029	13.4	292	10248	35.1	26.1	68.2
Pneumonia	1846	18464	10.0	542	7814	14.4	29.4	42.3
Other COPD & Allied Conditions	808	9808	12.1	470	6351	13.5	58.2	64.8
Symptoms, Signs, Ill Defined Conditions	4772	22801	4.8	696	5091	7.3	14.6	22.3

Source: Hospital Morbidity file, Newfoundland & Labrador Department of Health

CHAPTER 8
HEALTH MANPOWER

Historically, Newfoundland has experienced difficulty attracting and retaining qualified health manpower. Certain types of health manpower have been largely obtained from foreign sources with the result that quality varied and turnover was high. It should be noted, however, that this problem is faced by most provinces in Canada and is not unique to Newfoundland.

With the development of the Memorial University of Newfoundland School of Medicine, the number of Newfoundland-born and educated physicians has increased. There are still shortages in some specialties and in some locations. There is a shortage of many of these specialists across Canada. In addition, many areas of the province, particularly isolated communities, continue to rely on foreign-trained medical graduates and continue to experience high turnover rates.

Apart from physicians, manpower problems have also been experienced in the rehabilitative professions. Perhaps the most serious in terms of their potential impact on need for institutional services have been physiotherapy and occupational therapy. Lack of adequate services to meet the needs of the chronically ill and disabled population may have a significant impact on the need for long term care beds. As with the medical personnel, smaller isolated areas of the province have even more difficulty attracting and retaining qualified personnel than has St. John's.

Even if total numbers of personnel met national standards, there would continue to be problems unique to Newfoundland. Small isolated communities cannot, on their own, expect to provide opportunities which will ensure a continuous supply of qualified health care personnel. Therefore, arrangements need to be sought which will optimize the use of scarce personnel and resources. One arrangement which appears to have long term potential is multi-unit management which encourages sharing of personnel. Newfoundland has been aggressively pursuing opportunities for multi-unit management and should continue to do so. Specialist medical manpower should continue to be concentrated in regional centres where appropriate support services are available, but these specialists should be required to fulfill a regional role and serve other communities in their area.

In addition to overall shortages in the province, there is a maldistribution problem, with shortfalls being more serious outside St. John's.

Increasingly, planners realize that single-specialty practices do not work well. The difficulty has been that in many areas outside St. John's workload does not warrant attraction of two or more specialists. Additionally, for certain services, specialties are interdependent (e.g. obstetrics and pediatrics) in order to provide a program (e.g. level II neonatal pediatrics). Government has now, therefore, adopted the policy that in areas of recognized need, two specialists will be encouraged as a minimum practice. This policy should, in the long run, improve the capability of regional hospitals outside St. John's to provide true secondary services and to attract and retain qualified specialists.

Table 8.1 shows the number of specialists for selected specialties which are available and considered required for 1983 for St. John's and non-St. John's regions. Following are some comments on this table.

1) Only one specialty, general surgery, had a surplus of certified specialists both in St. John's and outside St. John's. There is an even greater surplus if non-certified general surgeons are included. This situation is expected to change as many of the general surgeons will reach retirement age in the next decade and fewer general surgeons are being trained. Also, a different type of general surgeon is now being trained with the result that they do not expect to cover the full range of procedures performed by general surgeons of the past.

2) In all remaining specialties listed, there are shortages both in St. John's and outside St. John's. The most acute shortages are in psychiatry and anesthesia, although the shortfall in anesthesia is largely offset by non-certified physicians. Ophthalmology also faces a critical shortage both in St. John's and outside St. John's.

Table 8.2 shows the number of physicians by specialty practicing in Newfoundland in 1976 and in 1982. Note that overall, the number increased from 547 to 678 for an increase of 24%. General practice, which increased from 324 in 1976 to 439 in 1982, accounted for the majority of the increase. There are now sufficient numbers of General Practitioners, however, distribution of the supply throughout Newfoundland and Labrador remains a problem. The other major growth specialty was internal medicine which increased from 39 to 56. Some specialties, notably general surgery, neurology, urology, and radiology actually declined in numbers during the period.

Table 8.1

PHYSICIAN STOCK, SELECTED SPECIALTIES
ST. JOHN'S, NON ST. JOHN'S
1983

Specialty	Stock 1983				1983 Estimated Requirements		Surplus or Deficit	
	Certified		Non-Certified					
	St. J	Non - St. J	St. J	Non - St. J	St. J	Non - St. J	St. J	Non - St. J
Internal Medicine	30	10	-	-	30	16	-	-6
Pediatrics	22	3	-	4	20	11	+2	-8
Psychiatry	17	2	3	3	29	12	-12	-10
General Surgery	13	16	-	4	14	21	-1	-5
Obstetrics/Gynecology	12	3	-	5	16	12	-4	-9
Ophthalmology	5	1	3	4	10	9.5	-5	-8.5
Otolaryngology	3	2	1	2	4	6	-1	-4
Orthopedics	8	2	1	1	10	7	-2	-5
Urology	4	2	-	-	5	4	-1	-2
Anesthesia	17	1	3	12.5	22	18	-5	-17
Pathology	9	4	5	2	16	8	-7	-4
Radiology	18	6	-	7	19	15	-1	-9

Note: Surpluses/deficits calculated relative to certified specialists.

Source: Newfoundland and Labrador Department of Health

Table 8.2

PHYSICIAN MANPOWER BY SPECIALTY IN NEWFOUNDLAND

Specialty	Year		% Change
	1976 No.	1982 No.	
Gen. Practice	324	439	35
Anesthesia	20	20	0
Dermatology	1	1	0
General Surgery	39	36	(8)
Int. Medicine	39	56	43
Neurology	5	4	(20)
Neurosurgery	2	2	0
Obs./Gynecology	18	18	0
Opthalmology	7	8	14
Orthopedics	10	10	0
Otolaryngology	5	5	0
Pediatrics	23	26	13
Physical Med.	0	1	10
Plastic Surgery	1	1	0
Psychiatry	18	23	27
Urology	10	6	(40)
Pathology	11	13	18
Radiology	14	7	(50)
Other Specialty	0	2	20
Total	547	678	24

() Brackets indicate negative change

Source: Newfoundland & Labrador Department of Health

Table 8.3 summarizes the specialist and non-specialist medical manpower by region in the province for 1983. Note that 60% of the physicians are located in St. John's and 78% of the specialists are located in St. John's.

Table 8.4 summarizes the provincial situation for selected non-medical health disciplines. Note that as of the time of the survey, there were 16 vacant physiotherapy positions and that of the 65 filled positions in physiotherapy, 49 were filled by non-Newfoundlanders. Similarly, in occupational therapy, 26 of the 32 filled positions are non-Newfoundlanders.

This report has recommended expansion of rehabilitation services. In order to develop these programs to their potential, it is essential that appropriate numbers of qualified rehabilitation personnel (nursing, physiotherapy, occupational therapy, speech therapy, psychology, etc.) be available on an ongoing basis.

In addition to health professionals and others who are formally involved in providing health care services, the role of volunteers should be recognized. In both acute and long term care settings, volunteers have played an important role and this role should be encouraged to an even greater extent in future.

Table 8.3

PHYSICIAN COMPARISON BY PRACTICE REGION
1983

Specialty Status	St. John's	Avalon Penin.	Burin/ Bonavista	Cent.	West.	North.	Lab.	Un - def.	Total	St. John's vs Non-St. John's			
										St. John's Count	%	Non - St. John's Count	%
Non-Specialist	336	56	40	93	76	17	19		637	336	52.8	301	47.3
Specialist	198	3	1	18	23	6	2	1	252	198	78.6	54	21.4
Total	534	59	41	111	99	23	21	1	889	534	60.1	355	39.9

Source: Newfoundland & Labrador Department of Health, Physician Manpower Data Bank

Table 8.4

OCCUPATIONAL STATUS OF SELECTED MANPOWER DISCIPLINES
1984

	Physio-therapy	Occup. Therapy	Speech Path.	Audiol.	Resp. Therapy	Radio-therapy	Nuclear Medicine
1) Positions							
Established	76	36	18 (1)	5	25	8	17 (3)
Filled	62	30	18	5	16	8	17
Vacant	14	6	0	0	9	0	0
2) No. of Non-Newfoundlanders Employed	49	26	7	2	2	4	9
3) No. of Qualified Personnel Residing But Not Working in Newfoundland	14	4	-	1		4 (2)	1
4) Annual Attrition	17	13	1		2	1	2
5) Projected New Positions Needed in Next 5 Years	40	15	5-	4	14-25	4	5
6) Required Annual Supply of Newfoundland Graduates for Next 5 Years	8-10	4-5	2	1	4	2	2-3

(1) Excluding those employed with School boards
(2) Only one potential employee
(3) Includes 2 Technicians providing service

Source: Department of Health, Newfoundland & Labrador

CHAPTER 9
IMPACT OF TECHNOLOGY

The Task Force on the Allocation of Health Care Resources sponsored by the Canadian Medical Association in its report "Health, A Need for Redirection" discussed a number of issues relevant to the use of technology in the provision of health care services. The chapter on Advances in Medical Technology (p. 41) should be read as background to this discussion relative to expected future bed utilization. A number of factors discussed in the chapter are particularly relevant to Newfoundland and Labrador.

Certain technologies have clearly led to reductions in mortality and morbidity. Technologies such as antibiotics, insulin and chemotherapy have led to such reductions, and in the case of antibiotics to substantial reductions in acute care hospital days for particular disease groupings. Other technologies, such as renal dialysis and neonatal intensive care equipment, have led to reductions in mortality rates but substantial increases in days of hospitalization for certain categories of patients. As stated in the aforementioned task force report,

"Modern technology has changed the nature of medical diagnosis and treatment, not only to save lives but to significantly affect the quality of life. Although some technologies have lowered health costs through prevention or through rapid and effective treatment, other technologies have raised costs. In general, it is now possible to keep sicker and sicker people alive longer and longer at greater and greater costs."[1]

Following are some observations about the impact of technology on the patterns of health care provision in Newfoundland and Labrador:

- Because of the relatively small and scattered population, expensive technology (and the associated resources such as manpower) have been, and will continue to be, provided in regional centres. As medical practice patterns change, larger proportions of the care requiring use of such technology will be concentrated in regional centres.

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1. Health: A Need for Redirection, CMA Task Force on the Allocation of Health Care Resources, p. 41.

- New medical graduates increasingly rely on technology to investigate problems or to validate their clinical judgment. As older, rural physicians become replaced with new graduates, reliance on technology and hence referrals to regional centres are expected to increase.

- Electronic information transmittal should reduce the requirement to transfer patients to regional centres. It should also create an overall reduction in admissions for purely investigative purposes.

- Many technological advances (e.g. laser surgery) permit procedures previously requiring inpatient stays to be done on an outpatient basis. Such developments will reduce inpatient admissions.

- Other technologies such as neonatal intensive care will lead to an increase in hospital days for particular disease groups.

- Another factor to be considered is the rising involvement of consumers in demanding access to particular technologies. As Canadians become more "litigation conscious", the use of technology to validate clinical findings may increase.

History has shown that technological advances can alter dramatically disease patterns in the population. During this past decade, technologies were frequently obsolete before they were in general use. It is difficult to predict what new technologies will appear during the next 10-15 years, let alone which ones will be in general use or what effects they will have on the utilization of hospital beds. However, at the risk of being grossly in error, past trends lead us to the following expectations for the future.

- By and large, the impact of technology should lead to a significant reduction in the use of hospital beds. Treatments now provided only on inpatients will in future be replaced by treatments that can be provided on an outpatient or home basis.

- As many types of equipment become smaller and smaller, opportunities for mobile monitoring will increase. This is now being done for EKG's and other types of tests for which patients were previously admitted.

- While generally the effect of technology should be to reduce hospital admissions and lengths of stay, there are other factors which will to some extent offset such reductions. Because of the capability to prolong life and to improve the quality of life, there will be increasing demands for and use of sophisticated technologies. Unless careful evaluation of the costs and benefits of new technologies occur, there could be substantial demands for use of expensive services and increasing hospital days. Also, there can be adverse side effects which increase hospital days.

- If, as predicted, advanced technology leads to a decline in hospital days and hence bed requirements, costs per patient day are likely to rise because patients then requiring inpatient care will be very acutely ill and often dependent on high technology.

- The impact of technology on the distribution of beds between institutions is also difficult to predict. When coronary care units first became fashionable, "ideal" medical practice was considered to be to admit all suspected myocardial infarction cases to such a unit. It is now recognized that patients in general do as well at home or in a quiet room in a small hospital. In this case, the trend has come full circle with care now considered to be appropriate at the local level rather than risking transfer to a "high tech" facility. With improved communications to regional centres, it is possible to care for some medical patients in small local hospitals and to do diagnostic workups locally. In the case of surgical procedures, however, care will continue to become more centralized. On balance, we believe the impact of technology will be to encourage more centralized provision of inpatient care, and improvements in technology at small local hospitals will allow prevention of some transfers of patients now occurring for diagnostic reasons to regional centres. Therefore, on balance, technology should not have a major impact on the distribution of services between regional centres and small hospitals.

There may, however, be some redistribution of workload between St. John's and other regional centres as a result of technological advances. As an example, the development of orthopedic services in Gander has clearly increased the workload there, although it is difficult to measure the extent to which this has offset increased demands in St. John's. If a CT scan, for example, is installed in Central Newfoundland, there should be a reduction in transfers to St. John's for this procedure. Also, in the regions outside St. John's, technology is only one factor in the provision of comprehensive services. Qualified manpower and backup services are also essential.

On balance, we believe there will likely be some shifting to regional centres (specifically Gander, Grand Falls, and Corner Brook) from St. John's as a result of technology, but any increases in bed utilization resulting from such a shift should be more than compensated for by reductions in bed utilization rates resulting from extended use of technology on an outpatient basis.

CHAPTER 10
THE CONTINUUM OF CARE

In recent years, the importance of developing resources to meet the needs for chronic and rehabilitative care, as well as for acute care, has gained increasing recognition. The CMA Task Force on the Allocation of Health Care Resources recognized that this continuum of care was a key factor in the provision of effective health care services. In the Task Force report, it was emphasized "that there should be enough flexibility within the system to enable an individual to move freely from one level of care to another, and an assessment service so that the needs of each individual can be periodically evaluated and met".[1]

In order to maximize the effective utilization of institutional beds and services, there must be a range of services along the continuum of care. Some of the services along this continuum need strengthening as discussed below in order to provide a better balance of services in Newfoundland and Labrador.

Home Care/Home Support

The Royal Commission discussed in some detail the weaknesses related to Home Care and Home Support services in Newfoundland and Labrador, therefore the following is only a brief summary of the Consultants findings which confirm that the problems as identified in the Commission Report still exist.

Throughout the province, there are numerous institutions and agencies involved in providing services to individuals in the home. In some areas, there are formalized "home care" programs, while in others, the public health nurses provide nursing services to the extent that resources permit. Some areas have Social Services homemakers working independently of other service providers, while in other areas formalized programs employ Social Services homemakers. In many areas, these homemakers lack adequate training and are not well supervised. Because of the 20 week nature of the program, continuity is a major problem. Nowhere in the province did the Consultants encounter an assessment and placement service which provided access to a full range of services.

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1. Health: A Need for Redirection, C.M.A. Task Force on the Allocation of Health Care Resources, p. 30.

Although the provision of Home Care/Home Support services is generally viewed as a very positive step, some of the existing programs are fragmented, inconsistent, and poorly organized. As a result there is an understandable reluctance on the part of health care providers and those who could benefit from such services, to rely on or take advantage of them.

There is a need to improve the image of Home Care/Home Support services in the province if the trend towards over reliance on institutional care is to be reversed. Government's initiative to coordinate responsibility for these services within the Provincial Departments involved is a very positive first step towards developing the comprehensive, coordinated and consistent services that are required.

Acute Care

As indicated in the Royal Commission report, acute care services have been well developed in Newfoundland, to the extent that there are excess acute care hospital beds in the province.

The Commission also addressed a number of other major issues to be resolved in rationalizing health care services in Newfoundland. These will not be repeated here. The following additional points from the Consultants review should, however be noted.

Traveling Clinic Services

There is a need to expand traveling clinics in order to improve services to local communities and to reduce diagnostic admissions to regional and tertiary care facilities. These clinics should be scheduled well in advance, be consistent and must provide follow up care.

Medical Referrals

Improved coordination is required in medical referral, especially between St. John's and the rest of the province. Doctors in some regions outside St. John's complain that patients are returned to them without comment and discharge summaries may reach them months later, too late to be of any use in treating the patient. They also claim there is over-referring in St. John's between specialists without reference to the family physician as a co-ordinator of care. On the other hand, St. John's physicians complain that the family physician often sends inadequate information with the patient and therefore new assessments are required. While some of these communication problems are inevitable, efforts should be made to improve these situations in order to improve patient care and eliminate unnecessary costs.

Rehabilitation

In some jurisdictions in Canada, Rehabilitation beds are included in the Acute Care bed formula, while some are designated separately with a separate method of allocation for these beds.

The term "rehabilitation" can be applied to many types of care including alcohol rehabilitation, psychiatric rehabilitation, developmental services for disabled children, active rehabilitation for trauma, slow paced rehabilitation for geriatric patients, patients with neurological disorders, etc. Rehabilitation is a term also frequently applied to a convalescent period (e.g. following orthopedic surgery) during which the patient receives physiotherapy treatment.

For purposes of this study, the consultants focused on the following types of rehabilitation:

Adult Special Rehabilitation

The only resource for adult special rehabilitation in Newfoundland and Labrador is the Leonard A. Miller Centre in St. John's. This centre operates a 20 bed unit which provides comprehensive, multidisciplinary rehabilitation programs aimed at restoring patients to maximum functioning in the community. The types of cases admitted to this unit include spinal cord injuries, brain damaged patients with high recovery potential, amputees and very selected strokes (young, high potential). This unit operates at a high occupancy rate and therefore must carefully select patients on a priority basis.

People interviewed in hospitals around the province have indicated that although it is difficult to gain admission for patients to the Miller Centre, those truly needing this type of rehabilitation (spinal cord injuries, young stroke victims, etc.), are admitted and their outcomes are very good. Therefore, at least superficially, there does not seem to be a major problem in this "special" rehabilitation area.

The Consultants requested information from all provinces concerning the bed guidelines used for various levels of care. Only two identified specific guidelines for rehabilitation beds. Responses were:

Ontario - 0.1/1000 - special rehabilitation
New Brunswick - 0.25/1000 all rehabilitation (general and special)
Newfoundland (actual) - 0.035 beds/1000 population

The type of resources required to provide special rehabilitation include highly specialized staff and equipment. In a province with a population of 567,700 (1981 census) it would not be appropriate to provide more than one such centre.

Although Newfoundland and Labrador is short of beds for this type of service relative to other provincial guidelines, since there is currently no real pressure on these beds and since they serve primarily a young to middle aged population, there does not appear to be justification to increase the number of beds at this time. However, if the role and referral policies were to change (i.e. greater referral of amputees for multidisciplinary assessment) then a further review of these beds would be required.

General Rehabilitation

General rehabilitation is usually considered to be a slower paced, less "high tech" type of rehabilitation for patients such as stroke victims, patients with neurological disorders, elderly amputees, etc. In most provinces this level of rehabilitation is provided in regional hospitals with specialty staff, but not necessarily under the direction of a physiatrist.

In Newfoundland and Labrador the only facilities for general rehabilitation are the 30 bed "geriatric" unit at the Miller Centre and 8 beds in the Special Care Unit of Western Memorial Hospital in Corner Brook. Obviously rehabilitation for these types of patients does occur in regional and local hospitals but because of lack of resources and perhaps lack of a co-ordinated multidisciplinary program, results are less than optimal. All hospitals visited indicated that they "do what they can" for these types of patients but they feel they are not providing as good programs as they should. The 30 bed unit at the Miller Centre primarily serves the Avalon Peninsula and the Western Memorial unit serves primarily the Western region. Therefore the rest of the province has very limited access to general rehabilitation services.

Following is a comparison of the guidelines available from other provinces for general rehabilitation:

- Newfoundland (actual) - 0.065/1000 population
- Ontario - 0.15/1000 population
- New Brunswick - included with special rehabilitation at 0.25 beds/1000

Hospital personnel interviewed all felt that the lack of these types of services had a definite impact on the needs and demands for long term care in their areas. In addition, the need/demand for rehabilitation services will increase with the aging of the population.

The following recommendations are made concerning development of General Rehabilitation beds in Newfoundland.

1. The guideline of 0.2 beds per 1000 population be adopted as a planning guideline for general rehabilitation beds.

2. Corner Brook and Gander should be identified as high priority for expansion of general rehabilitation services. Once these units are fully funded, the number of beds at the Miller Centre should be reviewed. The need for an additional 15-30 beds should be considered at that time. Also at that time, an additional unit should be opened in St. Anthony if feasible.

Pediatric Rehabilitation

A role study undertaken in 1984 by the Children's Rehabilitation Centre in St. John's identified the need to improve pediatric rehabilitation services throughout the province. These services are primarily outpatient and community based services with the Children's Rehabilitation Centre providing the inpatient care and specialty resource requirements.

There is a definite need to expand services in the community to meet the needs of children with disabilities and their families. Development of these services, however, does not affect this bed study, as the only beds providing this type of care are located at the Children's Rehabilitation Centre in St. John's.

TABLE R-1

APPLICATION OF ONTARIO FORMULA FOR GENERAL REHABILITATION BEDS TO REGIONAL POPULATIONS IN NEWFOUNDLAND

Region	1981 Census Population	Beds @ .2/1,000	1991 Projected Population	Beds @ .2/1,000
St. John's	138,565	28	149,006	30
Avalon	96,780	19	105,657	21
Burin-Bonavista	61,520	12	64,960	13
Subtotal, Eastern	296,865	59	319,623	64
Central	124,066	25	126,547	25
Western	96,455	19	97,882	20
Northern	18,855	4	20,598	4
Labrador	31,315	6	30,394	6
Total	567,556	113	595,044	119

Psychiatric Services

The Royal Commission on Hospital and Nursing Home Costs made the following recommendations on psychiatric services:

That:

"Government continue to give priority to the development of a comprehensive and integrated network for the diagnosis, treatment, care and rehabilitation of the psychiatrically ill that ensures access to appropriate services to all citizens of the province.

Regional community based support services be further developed so that services are provided closer to patients and their families.

Such regional community based support services be funded and provided through the Regional Long Term Care Board recommended by the Commission in order to ensure fullest co-ordination of available services and to avoid duplication.

Government endorse and accept the program developed by the Waterford Hospital and the National Institute on Mental Retardation for the deinstitutionalization of mentally retarded adults.

A formal liaison committee be formed between the Waterford Hospital and representatives of those general hospitals providing dedicated psychiatric inpatient units in order to promote a fuller understanding of the demands placed upon and the difficulties experienced by each facility, and further that no permanent or temporary addition to, reduction or modification of any psychiatric service offered by a general hospital be put into effect until such modification has been discussed in full by the liaison committee."[1]

Psychiatric mental health services are acknowledged as being underdeveloped in Newfoundland. Psychiatrists and other mental health personnel are in short supply and programs are minimal, particularly outside St. John's.

There is a need to develop and implement a comprehensive, coordinated system for a provision of mental health services to all ages in the province. The distribution of acute and long term beds, including those at the Waterford Hospital should be part of this comprehensive plan.

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[1] Page 463-464, Recommendations 4.105 - 4.109

As regional psychiatric services are developed, it is anticipated that the number of persons requiring referral to the Waterford Hospital will decrease, hence the number of beds required at this facility should decrease. The method of provision (i.e. inpatient vs. outpatient) of psychiatric services in future however, is not as clear as for obstetrical or pediatric services for example. In the absence of a comprehensive plan, the consultants were unable to make recommendations on beds required by region and facility.

Therefore, in line with recommendation 4.109 of the Royal Commission Report, no changes in the numbers of psychiatric beds in acute care hospitals have been recommended in this report. However, beds have been recommended in this report for the provision of old age psychiatric services in nursing homes.

Following is the background to the bed numbers recommended in this report for this type of care.

The Royal Commission discussed the need for psychiatric services to be provided for the elderly, both in the community and in five or six special hospital or nursing home units throughout the province. The Consultants have been unable to obtain more detailed information on the numbers of elderly people with psychiatric problems requiring institutional services and have, therefore, accepted the number of beds required as 200, which was the number identified in the Royal Commission report.

Given the time frame in which the Royal Commission made its recommendations, it is probably reasonable to assume that the 200 related to the 1981 population. Based on the 1981 provincial population of 42,993 aged 65 +, this would be 4.6 beds per thousand population. (Note that these are included within the overall guideline of 40 beds per thousand population aged 65 year and over). Application of this guideline to the regional populations yields the following numbers:

TABLE 10.1

Region	Population		Old Age Psychiatric Beds at 4.6/1000	
	1981	1991	1981	1991
Eastern	25538	33816	117	155
Central	9500	12594	44	58
Western	6215	8185	9151	29
Northern	1070	1418	1611	5
Labrador	670	893	1032	3
Total	42993	56906	65298	198

As indicated in the Royal Commission report, most nursing homes in the province have some patients they consider to have psychiatric problems. However, the only designated old age psychiatric units of which the Consultants were advised are as follows:

Waterford Hospital	100 beds
Lakeside Homes, Gander	25 beds
Western Memorial Hospital	15 beds
Harbour Lodge	98 beds
Miller Centre	35 beds

In addition to these beds, 25 of the 50 beds now under construction at the Bay St. George Home in Stephenville Crossing are designated for old age psychiatric services.

Provision of quality old age psychiatric services requires a number of factors including:

- Appropriate numbers of specially trained staff.
- Appropriately designed facilities.
- Access to a range of consulting staff including a psychiatrist with special interest in the psychiatric disorders of the elderly.

The lack of a comprehensive plan for development of psychiatric services throughout Newfoundland has limited the Consultant's ability to develop bed numbers and locations for old age psychiatric units. We have, therefore, considered the following factors in recommending locations of old age psychiatric units at this time:

1. Availability of a consulting psychiatrist in the region.
2. Existence of appropriately designed facilities to accommodate old age psychiatric services.
3. Expressed interest in developing old age psychiatric services in the facility.

The following is a brief discussion concerning each region:

Labrador & Northern

Because of the small population in these two regions and the highly specialized requirements of elderly people with psychiatric problems, it is recommended that these two regions be considered as one for planning old age psychiatric services.

There is a shortage of psychiatrists in the Labrador and Northern Regions but the service is available, and a recruiting program is underway. The St. Anthony Interfaith Home could be expanded to provide an appropriately designed unit, although the current facilities alone are unsuitable for this type of care. The home indicated a strong interest in developing this level of care.

Although the population of this region does not justify developing a 30-40 bed unit as recommended in the Royal Commission, the Consultants believe that geographic isolation warrants special consideration for this area. It is recommended that St. Anthony Interfaith Home plan and construct a specially designed old age psychiatric unit of 10-12 beds to serve as the regional facility for Labrador and the Northern Peninsula.

Western

Western Memorial Hospital currently accommodates 15 old age psychiatric patients in a nursing unit designed for rehabilitation. The unit is not appropriately designed for this type of care. The Bay St. George Home is currently undergoing a 50 bed expansion program. Twenty-five of these beds are specifically designed for old age psychiatry. Psychiatrists are available in the region and the Bay St. George Home has expressed interest in providing old age psychiatric services.

As indicated previously, application of the guideline to the population of Western region generated a requirement for 29 beds in 1981, rising to 38 in 1991. Therefore the 25 bed unit at Bay St. George will not be sufficient to meet all the future needs for the region.

The Western Memorial Special Care Unit will eventually require replacement, unless Corner Brook Interfaith becomes all level II and III. When plans are developed either for conversion of Corner Brook Interfaith or replacement of the Special Care Unit, a purpose designed unit of 18-20 beds should be planned for old age psychiatric services.

Central

The recently opened addition to the Lakeside Homes Limited in Gander contains a 25 bed unit designed for old age psychiatric residents. Space in this unit is inadequate. Therefore, it should be reduced in capacity to provide adequate support space for residents. Efforts should also be made to improve programming.

No other designated units in Central Newfoundland were identified to the Consultants. According to the guideline, Central Newfoundland should have 44 beds (1981 population), rising to 58 by 1991. Therefore, there was a shortfall of 19 beds in 1981 or 33 by 1991. An additional 30-35 beds should therefore be planned in this region.

The programs planned for the new facility in Botwood require clarification. There is no reason why this facility should not be appropriately planned to accommodate elderly people with psychiatric problems. With Grand Falls as the designated centre for psychiatry, there should be good access to psychiatric consultants. However, the Consultants are very concerned about staff resources in the existing Botwood Hospital. The philosophy of long term care is quite different from acute care. Therefore, in order to prepare staff for this change, an orientation and training program should be developed and made available to all staff at this facility.

An alternative to allocating beds at Botwood would be to add a purpose designed unit to North Haven Manor in Lewisporte. This area is also close to Grand Falls and has a good relationship with that hospital. Staff have expressed interest in developing old age psychiatric services. The existing building configuration is not designed for this level of care, and therefore a special unit would need to be added. If the unit were to be located in Lewisporte, however, reduction of the beds at Botwood or Carmelite would be required to meet the bed guidelines.

Eastern

In this region, there are in effect, 233 beds offering old age psychiatric services - 100 beds at the Waterford Hospital, 35 beds at the Miller Centre and 98 at Harbour Lodge. All three facilities are referral centres for the entire province.

Without a comprehensive plan for psychiatric services in the province, it is not possible to recommend bed numbers in this area. If appropriate community resources were available, some of those currently institutionalized may be cared for in purpose designed nursing units in nursing homes. Pending development of a provincial plan for psychiatric services, it is recommended that the Waterford and the Miller Centre be considered the focal point for old age psychiatric services in the Eastern Region and that very close liaison be maintained between the programs at the Waterford, Harbour Lodge and the Miller Centre. No additional beds have been recommended for this region.

Summary

It is recommended that the province develop and implement a plan for acute psychiatric services to be delivered on both an inpatient and outpatient basis. This plan should also address the provision of community based psychiatric services.

Following is a summary of the recommended bed numbers for special old age psychiatric units by region:

REGION	LOCATION	FACILITY	BEDS
Northern	St. Anthony	St. Anthony Interfaith	10-12
Western	Stephenville Crossing	Bay St. George	25
	Corner Brook	Western Memorial	18-20
Central	Gander	Lakeside Homes	25
	Botwood/Lewisporte	Botwood or North Haven	30-35
Eastern	Carbonear	Harbour Lodge	98
	St. John's	Waterford Hospital	100
	St. John's	Miller Centre	35
		Total	341-350*

* The total number of beds reflects a continuation of the same number of existing beds in Eastern Region which is above the numbers outlined in Table 10.1. The consultants believe the beds in Eastern Region could be reduced when Regional Psychiatric Services become available as part of the Provincial Plan.

Long Term Care

For the past several decades, the development of acute care health services has been the focus of much attention. As a result, acute care and the services involved are generally well understood.

In contrast, it has only been in the last several years that long term care has received much attention. With the realization that our society is aging, has come the recognition that special services are required to meet the complex needs of the elderly and that these are not well developed.

The key to provision of appropriate long term care services is flexibility to meet the needs of the individual. A range of services should be provided which will assist people in need of care or at risk for requiring care to live independently in their own home and community for as long as possible. In addition to the availability of services, there must be comprehensive assessment and placement services which can assess all needs of the patient and access the most appropriate services to meet those needs. As described by Koff:

> "It (long term care) encompasses both institutional and non-institutional services and requires co-ordination of public policies, funding and case management to provide appropriate options for service to individuals whose needs inevitably change over time. Long term care is intended to provide an individual user with choices among a variety of services, used singly or in combination, that will minimize the disabilities of chronic illness, support as independent a life style as is practical, and prevent further complications of chronic conditions.
>
> Long term care in its broadest interpretation should also encompass the education and training of providers of services, the preventive services that help avert chronic illness, and the basic research that seeks to circumvent the illnesses so often associated with the later years."[1]

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1. Koff, Long Term Care: An Approach to serving the Frail Elderly

A. Long Term Care Services

In order to facilitate the maintenance of the highest level of independence possible by those, who, for whatever reason,are chronically ill or disabled, ideally a wide variety of services should be available. While by no means all inclusive, the following is an outline of the types of services to which individuals may require access in order to retain maximum independence. Since not all of these services will necessarily be feasible in all areas of Newfoundland and Labrador due to geographic and social-cultural differences, each area should consider how it can best develop services to reduce reliance on institutional care. In addition, it is essential that all services be co-ordinated and that incentives be developed to encourage use of non-institutional services.

Home Care Services

The services outlined below are important elements of a comprehensive home care system. It will not be possible to provide access to all of these services in all areas of the province for reasons discussed above. Therefore it is essential that innovative ways of gaining access to an appropriate range of services be explored. For example, while it may not be possible to provide professional physiotherapy services in every community, it should be possible to provide access to physiotherapy services through training an individual as a physiotherapy aide to work under the supervision of a professional. Many examples exist in the province where access to services is provided through sharing of scarce human resources. Opportunities to increase sharing of resources should be encouraged wherever possible.

Following is a list of services which should be considered as part of a home care system to meet the needs of persons living alone in the community, with a family member or friend, in senior citizens' housing, etc.:

- Home nursing care (e.g. catheter care, injections, dressings)
- Homemaker - personal care services (e.g. bathing, dressing)
- Homemaker - household services (e.g. cleaning, meal preparation, shopping)
- Household maintenance (e.g. grass cutting, snow removal, minor repairs)
- Physician services
- Rehabilitation services (e.g. physiotherapy, occupational therapy, speech therapy)

Telephone reassurance, emergency assistance, friendly visiting
Respite care (day, night, weekend, vacation, emergency)
Equipment loan (e.g. wheelchairs, walkers, hospital beds, commode chairs)
Medical supplies (e.g. incontinent pads, catheters, ostomy supplies)
Home adaptation

Day or Outpatient Services:

Note that planning for such services should include consideration of transportation methods.

Clinic services (diagnostic, treatment, education, including medical, nursing, rehabilitative, dental, eye, ear, foot care, adjustment of medications)
Meals
Recreation, exercise, socialization
Personal care (e.g. bathing)
Respite care
Counseling (psychiatric, social, legal, financial)

Sheltered Housing:

Some people will choose to live in a sheltered housing setting because of the additional security it may be considered to provide. The primary settings in which this type of services are found include:

Foster homes
Boarding homes/personal care homes
Congregate apartments
Seniors' cottages (primarily those adjacent to nursing homes)
Nursing homes providing level I care

In addition to the services listed as being provided in the home, these facilities generally provide ongoing supervision and social and recreational activities, with the exception of seniors' cottages which do not generally provide supervision.

Institutional Services:

For those requiring more services than can be provided through an appropriate combination of the services and locations indicated above, institutional services may be required. The types of services provided in an institutional setting include:

- 24-hour professional nursing care and supervision
- 24-hour personal care
- rehabilitation services
- respite care
- convalescent care
- emergency (short term) care
- palliative care
- short term acute medical care
- recreation, socialization
- transportation
- pastoral care
- counseling
- therapeutic dietary services (i.e. counseling, meals, etc.)

These services can be provided in nursing homes or long term care units in hospitals.

B. Overview of Long Term Care in Newfoundland

Until recently, long term care in Newfoundland has generally been perceived as meaning placement in a Senior Citizens' Home. Although Home Care Programs have been in place in several areas of the province for many years, most concentrated upon provision of acute care.

In recent years however, some innovative programs, in particular home care (with a focus on long term/chronic care), home support services, day care, respite and meals on wheels have been developed. While these have helped a great deal in meeting some of the needs in some areas of Newfoundland and Labrador, these services have been characterized in many areas by a lack of coordination and they have not been well integrated with other available long term care services. Perhaps the most critical problem however, is that these services, for many reasons have not been consistently available. This has resulted in an over-reliance on institutional care for those who suffer from chronic illness and/or disability.

In addition to the above, there are problems with the distribution of services across the province with some areas having a large surplus of institutional beds and duplication among other services provided and other areas where there are no services available for long term care.

A lack of rehabilitative services however, is experienced throughout the entire province with, perhaps, the exception of St. John's where rehabilitation beds are available, although limited. It is recognized however, that obtaining adequate numbers of professionally trained personnel including Physiatrists, Physiotherapists and Occupational Therapists has been a major problem for Newfoundland.

Previous studies have confirmed that as a result of the above, there are people living in institutions who could be discharged to live independently or semi-independently in the community in sheltered housing with appropriate support services. Others who need nursing home care are inappropriately placed in acute care hospitals or are living in unsatisfactory conditions in the community.

On a more positive note however, the attitudes towards and ideas regarding long term care demonstrated by persons involved in the provision of such care, by those involved in the provision of acute care and by interested members of the community who met with the consultants were very progressive and exciting. It is obvious that the dedication to the provision of the best care possible for the elderly of this province is very strong and that the climate is right for change and many innovative developments to this end.

C. Long Term Care Services Available in Newfoundland and Labrador

Having discussed long term care in Newfoundland in somewhat general terms, the following is an outline of findings regarding the services which are currently provided in Newfoundland and Labrador:

Home Care Services

The Consultants' findings regarding Home Care services have been discussed previously, therefore no further comment will be made here.

Day Services

As with home care, a number of services are available in the province but they are not well developed. Access to medical services is not a problem in most areas, although there are only a few organized comprehensive outpatient programs. Generally, physician visits are organized by individual practitioners, with referrals for diagnosis and treatment often requiring follow up on another day (at great inconvenience and often expense to the patients). Preventive dental, vision, hearing and foot care appeared lacking in most areas. This may reflect the fact that many of the elderly, their families and also caregivers appear to know little, if anything about the benefits provided by the Provincial Government.

A few nursing homes have developed day care programs. However, in all areas, the space and personnel they are able to provide is insufficient to provide comprehensive programs.

Sheltered Housing

Sheltered housing is available in Newfoundland in a variety of settings including the following:

I Licensed Boarding Homes

The largest inventory of sheltered housing in the province is in the licensed boarding homes. These homes are operated by private entrepreneurs and are separate and distinct from the homes operated by the Waterford Hospital.

Residents in the licensed boarding homes, which range in size from 3 to 44 beds, are assessed and placed by the Department of Health. Most of these facilities are located on the Avalon Peninsula and many accommodate primarily psychiatric patients. Personal care, room and board, and in some cases limited social and recreational programs are provided.

It should be noted that there are also unlicensed boarding homes throughout Newfoundland and Labrador, the number of which has been increasing in recent years. These facilities were not addressed by this study.

II Foster Homes

Foster homes are utilized in some areas of Newfoundland. However in most areas, the idea seemed relatively new and the possibility of this option appears not to have been well explored. Although this option would certainly not meet the needs of all long term care candidates, the development of foster homes should be considered for all areas. Such homes could be used not only for permanent placement but also for respite care, short term emergency placement, convalescent care and seasonal placement.

III Congregate Living Facilities

Congregate apartments have not been formalized in Newfoundland, although we understand arrangements similar to a congregate exist in several locations in Newfoundland. Congregate living facilities are group housing arrangements in which private living quarters are combined with some group spaces such as kitchen and dining facilities. Residents share in household chores and in support and care of other residents. Residents requiring services beyond that available within the group receive these services from the home care services. Some residents of the congregate may also use local day care or day hospital services.

IV Senior Citizen Cottages

Seniors cottages are available in many locations in Newfoundland. Some are located adjacent to nursing homes, while others are completely independent*. On their own, they are not strictly sheltered housing since no supervision is provided. However, in many cases where these are located adjacent to a nursing home or hospital, the facility has accepted the responsibility of providing care for these residents. In particular, meals on wheels, day care and emergency nursing care are frequently provided to cottage residents where cottages are operated by nursing homes.

* Note that only Senior Citizens Cottages affiliated with Nursing Homes have been included in the inventory of services discussed later by Region.

It was brought to the Consultants' attention that, at least in some areas, the seniors living in these cottages are by and large, an overlooked population from the standpoint of being in "need" or at risk. The assumptions may be that it is primarily the "well elderly" who live in the cottages and that they do not need services; therefore they do not receive them. Knowledge among Public Health Nurses and Social Workers regarding what level of supervision or services are provided by an adjacent or associated Nursing Home may also be limited.

Another concern that came to our attention is that in some instances, there is an expectation by those living in senior citizen cottages that are associated with a nursing home, that they will have priority access to the facility when they needed it. This is an accurate assumption in only some cases.

V Granny Flats

Although not strictly sheltered housing, there is another housing option that should be considered in Newfoundland. Granny flats, now being tested in Ontario, are a housing option which may have application in Newfoundland. These encourage independent living while maintaining close access to the support of family members.

Institutional Setting

There are currently 2,368 beds in nursing homes and hospitals offering formalized 24 hour personal and nursing care services. All provide basic care, but additional programs vary greatly. Rehabilitation services are minimal. Placement for the most part is regarded as permanent and despite the fact that some residents do progress to a lower level of care, they still remain residents of the nursing home due to lack of reliable community support services. Respite care is available in some areas, both in nursing homes and in acute care hospitals, but it is not formally recognized and not necessarily coordinated with other community services. Only one of the nursing homes visited held a bed open for short term emergency placements or convalescent care. Most homes provide recreation, socialization, pastoral care and transportation services, although services vary substantially between homes.

Nursing homes in Newfoundland and Labrador were almost all designed initially to accommodate all level I residents. At that time, public policy encouraged seniors to enter an institution. The government of Newfoundland and Labrador is now encouraging placement of residents requiring level I care in non-institutional settings. Most Homes still have some level I residents remaining, although most no longer admit such residents. This, coupled with the fact that priority must be given to admitting the large numbers of level III residents, has meant that fewer beds are available in nursing homes for level I residents. This trend is expected to continue so that eventually all nursing home beds will be for level II and III care* and level I care will be provided in other community facilities such as previously described. A certain amount of flexibility will, of course, be necessary to accommodate individuals who require only level I care, but whose spouse is receiving heavier levels of care in an institution.

D Background to Recommendations Regarding Long Term Care

The following comments are provided as context to the recommendations regarding long term care services which are detailed in the Regional Plans discussed later in this report.

Care of the Elderly, Chronically Ill and Disabled - Nursing Home versus Home Care

There are two interesting opposing threads running throughout comments made to the consultants regarding the expectations of the Newfoundland population. On the one hand, we were told that Newfoundlanders are strongly committed to caring for their elderly and disabled at home. At the same time however, we were told that home care is often not accepted when offered because of the fear that accepting these services would reduce the priority of the individual on the waiting list for the nursing home. This would appear to suggest that nursing home placement is preferred to being cared for at home with the support of home care services. In fact, the system has encouraged this attitude since the coming and going of home support services has meant that the only reliable means of obtaining necessary care was through institutional placement.

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* In some existing facilities, physical limitations will preclude provision of level II - III care exclusively.

Two other interesting points were raised about Home Care. The first of these is that some communities expressed concern that if Home Care services were developed, it may reduce or eliminate their chances of obtaining approval to build a Nursing Home. The other point is that should an individual agree to remain in their home and avail themselves of Home Care services, in the event that their health deteriorated, there has been no guarantee that they would be able to gain admission to a Nursing Home. This has caused many to seek admission to a Nursing Home, even though at the time, they were not in need of nursing care services.

With all of this in mind, if the commitment to caring for the elderly and chronically disabled at home is to be maintained in Newfoundland, the highest priority must be given to developing home care, home support, respite services, day care services, etc. However, steps should be taken to ensure that these services are not merely an add-on to existing services (as has been the case in many provinces) but rather, that they are viewed as an alternative to institutional services. Reliance on these services will not occur quickly, particularly in view of past experience. Caregivers will need to be convinced that the services will be reliable and must educate families to use the services appropriately. Furthermore, families must be assured that if and when they are no longer able to cope with providing care in the home, access to institutional care will be available.

Number of Long Term Care Beds Recommended

There are several points to be considered in relation to the recommendations made later in this report regarding the number of beds which should be provided for long term care.

First and foremost, the Consultants recommend that before any more beds are provided, it is essential to ensure that the beds currently available are being used appropriately. Also Home Care/Home Support services should be well developed throughout the province before providing additional beds as these services may reduce the number of beds required below that indicated as per the norms.

Secondly, it is essential that institutional services not be considered in isolation from the rest of the services recommended as part of the long term care system. The number of beds recommended reflects the fact that overbuilding leads to inappropriate placement and to attitudes which increase reliance and hence demands on the institutional sector.

The number of beds recommended through application of the norms are considered by the Consultants to represent the maximum numbers of beds required and it should be possible to reduce these numbers when comprehensive home care/home support services are available.

During the next three years, government should concentrate on the development of home care and related services and should provide additional nursing home beds only where there is an unquestioned shortage.

Time Frame for Recommendations

Because of the significant shortfall in alternative services and because of the lack of meaningful information on needs, the Consultants have not recommended beds to be provided after 1991. Over the next three years, improved information systems should be put in place to permit a more complete assessment of needs. An evaluation should be undertaken again in 1989 to determine whether additional beds are required to meet needs beyond 1991.

Nursing Home Construction

The current system of funding capital construction for nursing home facilities requires review. Most facilities are currently funded through a mortgage arrangement with Central Mortgage and Housing Corporation. In even the newest of Homes, the Consultants found many inappropriate features and costly errors in design. In particular, long institutional units permitting little or no visual supervision characterize these facilities. There are significant shortcomings in support and clinical spaces including nursing stations, utility areas, storage, bathing facilities, lounge and activity areas, etc. In general, space to provide outreach services (e.g. day care areas, kitchen sized for extra meals, etc.) is not provided in facilities built to CMHC specifications because CMHC guidelines are for residential shelter, not for institutional facilities. The Consultants were also advised that CMHC imposed restrictions on admission criteria (e.g. no residents under age 60) which are inappropriate from a health care point of view.

In view of the above, it is essential that a program for correcting these shortcoming in existing facilities be undertaken to permit conversion of nursing homes to provide all (or almost all) level II and III care. Also, as extra nursing home beds become available throughout the province, some homes should reduce capacity and undertake renovations to provide adequate space for residents and for community outreach programs. This program should be carried out with the assistance of qualified planners knowledgeable about the needs of those requiring long term care.

In relation to construction of new nursing care facilities, if the Government of Newfoundland is to continue to fund capital construction through CMHC, it should be prepared to supplement CMHC funds to ensure that these new facilities are constructed to nursing home, not residential standards.

Government must also ensure that these facilities are properly planned and designed such that they are appropriate to meet the needs of the area in which they are being built; the needs of those under 65, as well as those over 65 who require long term care and when special services such as old age psychiatric services are to be provided, that the facilities are designed with the specific purpose in mind.

Finally, when considering the construction of a new facility, the feasibility of shared services should be considered. In some areas discussed later in this report, it may be appropriate to develop health centres to provide inpatient, outpatient, long term care, and community services on one site. In such situations, significant potential exists for sharing of services and therefore containment of costs. In other areas, although only long term care facilities will be required, it may be possible to share services with other such facilities or hospitals in the vicinity.

Provincial Standards

Services and programs provided in nursing homes vary throughout Newfoundland and Labrador. In an attempt to ensure a consistent range and quality of services for residents of nursing homes in Newfoundland and Labrador, the Government should develop standards to address these issues. Patient classification systems should be developed in nursing homes and personal care facilities.

The Consultants have been advised that the change to global budgetting and increases in budget allocations should permit improvements needed to address these issues in future.

Level I Facilities

Although our terms of reference did not include discussion of the quality of care or level of services provided in licensed boarding homes, there are certain issues which directly impact on our ability to make practical recommendations in each area. These are as follows:

The vast majority of licensed boarding home beds are located on the Avalon Peninsula. For many residents outside the Avalon, this factor has led to the belief that moving to a boarding home meant moving to the Avalon. Also, the image of the Licensed Boarding Home Program, rightly or wrongly, has not been very positive.

On the other hand, by and large, nursing homes have positive images in their communities. Consequently, the perception that a person in need of care should go to a nursing home rather than a boarding home, is reinforced. It is essential therefore that the quality of care in boarding homes be consistently good and that they have a good public image if they are to be utilized appropriately.

In some areas, there may be opportunities for alternative methods of providing level I services, such as congregate living or residential care facilities under the auspices of a nursing home or hospital. Throughout the district plans which follow in this report, the Consultants have referred to the development of congregate living facilities and/or licensing of Boarding Homes to address needs for level I care. This is not meant to be construed that only these two types of facilities are considered appropriate in the Newfoundland context. Rather, consideration should be given to the full range of alternatives appropriate for such care.

Assessment and Placement

Another important issue related to personal care homes is that of assessment and placement. All level I facilities, whether boarding homes, nursing home, personal care, foster care, home care, congregate living, share a home or whatever, must be part of the overall assessment and placement system put in place. This is particularly important since at the present time it appears that there are instances of people "falling through the cracks". For example, those who require care beyond what can be provided in boarding homes but who do not require sufficient services to be admitted to a nursing home (at least not without a long wait) are not routinely referred to another level or type of service (i.e. Home Care). They are therefore at risk of developing more serious problems which may eventually require a higher level of care than was initially required.

Nursing Home Admission Criteria

There is a need to coordinate admission criteria for long term care facilities in order to meet the needs of all categories of patients. At present there is no system to ensure that people have access to appropriate services. For example, some nursing homes do not admit young residents; some admit only level I residents; others impose other restrictions (e.g. behaviour).

Housing for the Elderly

Although discussion of housing for elderly people is not strictly within the mandate of this study, housing conditions are a major factor in determining whether a person at risk will require institutional care. From the Consultants' visits to all regions of the province, it appears that allocation of housing funds has not been well coordinated with other services. Also, concerns have been expressed about increasing the risk to the elderly by encouraging them to move into cottages outside their own communities and away from the support networks in these communities. Since health is a provincial responsibility, housing, particularly for seniors, should also be a provincial responsibility. The Consultants were advised that efforts are currently being made to bring this about and endorse this move wholeheartedly.

CHAPTER 11
GENERAL RECOMMENDATIONS

Despite the many good health care services that have been developed, there are shortfalls in the range of services in Newfoundland. If the trend towards reliance on institutional placement for the elderly and chronically ill and disabled is to be reversed, high priority must be given to development of a coordinated network of services aimed at keeping people in their own homes in their own communities. Such coordination requires major readjustments in the way services are delivered in Newfoundland. Jurisdictional boundaries at both government and local service delivery levels must be crossed, more choices must be available and resources must be reallocated to rehabilitation programs and service coordination. It is also essential that attitudes of health professionals and the general public change, particularly related to reliance on institutional care.

The general recommendations outlined below apply to the continuum of health care services in Newfoundland and are meant to augment the specific recommendations regarding the plans for Regional health care services which follow:

1. It is essential that comprehensive home care/home support services be developed throughout Newfoundland and Labrador. Steps should be taken to ensure that these services are not merely an add-on to existing services (as has been the case in many provinces) but rather, that they are viewed as an alternative to institutional services. Therefore, it is recommended that these services be fully developed and coordinated with other long term and acute care services and that their impact on the requirement for institutional beds and services be evaluated before expanding the number of beds for acute and long term care in the province.

   It is recommended that in some areas of the province (detailed in the following sections) test sites for Home Care/Home Support services be established.

2. The role of volunteers and non professionals who have been provided with training in basic nursing/personal care, should be expanded in home care to augment services provided by professional personnel.

3. Funds currently available and any new funds allocated for needs assessment should be directed towards assessment of the need for home care and other community support services.

4. Housing, particularly for seniors, should be coordinated with the provision of other long term care services and should be a provincial responsibility.

5. Sufficient numbers of sheltered housing alternatives should be developed throughout the province. Alternatives should include a range of options such as foster care, congregate apartments, personal care homes, etc. These must be of appropriate quality and provide services designed to meet the needs of each community. In the case of Licensed Boarding Homes (i.e. non Waterford Homes), standards should be upgraded and educational opportunities should be provided to operators particularly in homes where residents are primarily psychiatric or ex-psychiatric patients. Access to support services for residents of boarding homes is also critical. Consideration should be given to expanding services available through the Waterford Hospital such that they would be accessible to Boarding Home operators for education and support and to residents for programs.

6. More flexibility in funding is required to permit improvements in the range of health and social services available to meet the needs of Newfoundlanders. This will require improved organization of and coordination between Government Departments including Health, Education, Social Services, Housing and Transportation.

7. Information regarding preventive health benefits for senior citizens should be made more readily available to Seniors, their families and caregivers.

8. There should be an aggressive campaign to educate health care professionals and the general public to reduce over reliance on the health care system and on institutional placement for the elderly or chronically ill or disabled.

9. Preventive health educational programs aimed at lifestyle modification (especially related to smoking behaviour) should be promoted since aggressive campaigns in the past have led to significant reductions in hospitalization for C.V.A.'s, etc.

10. In line with recommendation 5.29 of the Royal Commission report, education programs must be provided for staff working with long term care patients to improve their skills in encouraging independence.

11. Nursing homes should provide rehabilitation services to ensure that all residents function at the highest level possible. In addition, some nursing homes should develop services designed specifically for persons who may require nursing home care for a period of time, but who are capable of being rehabilitated to a point where they can return to the community when appropriate support services are available.

12. Comprehensive rehabilitation and psychiatric services should be developed on a regional basis.

13. In accordance with the recommendation of the Royal Commission, comprehensive assessment and placement services, preferably on a regional basis must be provided to ensure appropriate placement for all patients.

14. Nursing homes should provide a certain proportion of beds for respite care, short term emergency admissions and convalescent care. These beds should be over and above the beds allocated by the guideline of 40 beds per thousand population aged 65 and over. Global budgeting should make this feasible.

15. If funding of nursing home construction continues to occur through CMHC, the Government of Newfoundland and Labrador should supplement these funds to ensure provision of adequate space and programs (i.e. physiotherapy and occupational therapy) for residents and for outreach programs such as day care/day programs.

16. Expansions or new construction of nursing homes should be undertaken with the assistance of qualified health care planners knowledgeable in the appropriate programming and design of facilities for the elderly.

17. When construction is being considered for Nursing Homes, Hospitals and Health Centres, the facilities should be designed as multipurpose centres to include inpatient accommodations as well as ambulatory care facilities for acute and long term care. In addition, related services such as Public Health, Social Services and physician offices, etc. should be accommodated (where the need exists) within these centres.

18. Comprehensive education, prevention and treatment programs are required, especially for persons known to be at high risk, including diabetic and hypertensive patients, in order to reduce hospital and nursing home admissions.

19. Incentives should be developed to encourage physicians to alter their patterns of practice, in particular, as it relates to inpatient care. To encourage these changes in practice, the fee structure could be changed such that it would encourage:

    - participation in multi-disciplinary assessment and care for the elderly or patients with chronic disorders
    - use of outpatient services to replace inpatient services, especially preadmission diagnostic testing for medical cases
    - improvement in the consistency of visiting clinics
    - provision of services to isolated communities.

20. Appropriate facilities and staff should be provided to encourage reductions in inpatient utilization. It should be possible to accomplish this through reassignment of existing staff in institutions rather than through net increases in staff. In particular, further use of the following services is encouraged:

    - hostel*
    - day surgery
    - day hospital
    - outpatient counseling
    - coordinated preadmission diagnostic testing

21. Formalized discharge planning programs should be provided in all acute care hospitals.

22. Acute care beds should be reduced by at least 350. General rehabilitation beds should be increased by about 40. Levels II and III beds should be increased by about 530 of which approximately 75 will be created through conversion of level I beds and approximately 460 will be created through new construction.

    Note that 290 of the 460 beds recommended to be created through new construction have already been committed.

23. The Government should implement a program of ongoing needs evaluation for all levels of service. In particular, the need for all long term care services should be reviewed at three year intervals. An information base generated by the assessment and placement service will be an important factor in carrying out this evaluation.

* Referral of patients by physicians to hostel facilities may be limited in situations where there is no pressure on hospital beds. Also, some physicians have indicated that they will not use hostel facilities for their patients if the patient is required to pay. In areas where patients are now required to pay for hostel accommodation however, such facilities are being well utilized. This issue may require further study.

Table 11.1

SUMMARY OF NET BED REDUCTIONS RECOMMENDED ACUTE CARE

Region	Location	Facility	1984/85 Reported Acute Beds	Recom'd Acute Capacity	Net Reduction (Addition)
Labrador	Labrador City	Cptn Wm Jackman Mem'l. Hospital	47	43	4
	Goose Bay	Melville Hospital	45	45	0
	Total, Labrador		92	88	4
Northern	St. Anthony	C. S. Curtis Mem'l. Hospital	146	90-100*	46-56
	Port Saunders	Port Saunders Hospital	16	4	12
	Total, Northern		162	94-104	58-68
Western	Bonne Bay	Bonne Bay Hospital	20	2-4	16-18
	Corner Brook	Western Mem'l. Regional Hospital	267	267	0
	Stephenville	Sir Thomas Roddick	89	56	33
	Channel	Charles L. LeGrow	40	20	20
	Burgeo	Burgeo Hospital	18	6	12
	Total, Western		434	351-353	81-83
Central	Baie Verte	M.J. Boylen Hospital	31	25	6
	Springdale	Springdale Hospital	25	10	15
	Grand Falls	Central Nfld Reg'l. Hlth Centre	197	172	25
	Botwood	Botwood Cottage Hospital	46	0	46
	Buchans	A.M. Guy Memorial Hospital	12	2	10
	Harbour Breton	Harbour Breton Hospital	19	0	19
	Hbr Breton-St. Albans	New Facility	0	10	(+10)
	Twillingate	Notre Dame Bay Memorial Hosp.	53	37	16
	Fogo	Fogo Hospital	18	6	12
	Brookfield	Brookfield Hospital	30	10	20
	Gander	James Paton Memorial Hospital	162	134*	28
	Total, Central		593	406	187

Table 11.1

SUMMARY OF NET BED REDUCTIONS RECOMMENDED ACUTE CARE (con't)

Region	Location	Facility	1984/85 Reported Acute Beds	Recom'd Acute Capacity	Net Reduction (Addition)
Eastern 1	Bell Island	Dr. W. Templeman Hospital	40	6	34
	St. John's Hospitals**	St. Clares Mercy Hospital	323		
		Health Sciences Centre	342		
		Grace General Hospital	292		
		Dr. C.A. Janeway Child Health Center	193		
	Subtotal, St. John's		1150	1185	(+35)
	Subtotal, Eastern 1		1190	1191	(+1)
Eastern 2	Old Perlican	Old Perlican Hospital	23	0	23
	Carbonear General	Carbonear General Hospital	100	100	0
	Placentia	Placentia Cottage Hospital	32	10	22
	Subtotal, Eastern 2		155	110	45
Eastern 3	Bonavista	Bonavista Cottage Hospital	15	15	0
	Grand Bank	Grand Bank Cottage Hospital	30	2-4	26-28
	Burin	Burin Cottage Hospital	31	0	31
	St. Lawrence	U.S. Memorial Hospital	22	0	22
	Salt Pond	New Hospital	0	60	(+60)
	Come by Chance	Come by Chance Cottage Hosp.	24	0	24
	Clarenville	Dr. G.B. Cross Hospital	0	60	(+60)
	Subtotal, Eastern 3		122	137-139	(+15-17)
	Total, Eastern		1467	1438-1440	27-29
	GRAND TOTAL		2748	2377-2391	357-371

* Excludes Rehabilitation Beds.

** Excludes Waterford and Children's Rehabilitation Centre.

Table 11.2

SUMMARY OF RECOMMENDATIONS GENERAL REHABILITATION BEDS

Region	Facility	Current Capacity (Rehab)	Recommended Capacity	Net Change
Northern	Charles S. Curtis Memorial Hospital	0	10	10
Western	Western Memorial Regional Hospital	8	24-30	16-22
Central	James Paton Memorial Hospital	0	10-12 (+8-10)*	10-12 (+8-10)*
Eastern	Miller Centre	30	30	0
	Total	38	74-82 (+8-10)	36-44

* The consultants expect that in the long run an additional 8-10 Rehabilitation beds will be required in Gander. However, development of these beds will depend on the extent to which Rehabilitation services can be provided on an outpatient basis. Therefore, the need for these beds should be evaluated after inpatient and outpatient services are available.

Table 11.3

SUMMARY OF RECOMMENDATIONS
LEVEL I, II & III BEDS IN NURSING HOMES & HOSPITALS

Region & District	Facility	Total Capacity 1985/86	Level II-III Capacity		Level I Capacity		Respite Capacity	Additional Level II-III Beds			Levels I,II,III & Respite Capacity 1991 Recom'd
			1985/86	1991 Recom'd	1985/86	1991 Recom'd	1991 Recom'd	Through Conversion of Level I	Through New Constr'n*	Total	
Labrador & Northern											
Labrador	Harry L. Paddon Home	53	46	46	6	6	1	0	0	0	53
Northern	St. Anthony Interfaith	48	36	68	12	4	2	8	24	32	74
	Total, Labrador & Northern	101	82	114	18	10	3	8	24	32	127
Western											
Western A	Western Mem (Spec. Care)	60	52	60	0	0	0	8 **	0	8	60
	Corner Brook Interfaith	102	51	93	51	0	4-5	42	0	42	97-98
	Bonne Bay	0	0	29	0	0	1	0	29	29	30
	Burgeo	0	0	16	0	0	2	0	16	16	18
	Subtotal	162	103	198	51	0	7-8	50	45	95	205-206
Western B	Bay St. George	78	63	95-96	15	15	2-3	0	32-33	32-33	112-114
	Charles LeGrow Centre	18	18	16	0	0	2	0	0	0	18
	Subtotal	96	81	111-112	15	15	4-5	0	32-33	32-33	130-132
	Total, Western	258	184	309-310	66	15	11-13	50	77-78	127-128	335-338

Table II.3
(con't)

Region & District	Facility	Total Capacity 1985/86	Level II-III Capacity		Level I Capacity		Respite Recom'd Capacity 1991	Additional Level II-III Beds			Recom'd Capacity 1991 Levels I,II,III & Respite
			1985/86	1991 Recom'd	1985/86	1991 Recom'd		Through Conversion of Level I	Through New Constr'n*	Total	
Central											
Central A	M.J. Boylen	8	8	8	0	0	2	0	0	0	10
	Valley Vista	104	67	90	36	12	2	23	0	23	104
	Subtotal	112	75	98	36	12	4	23	0	23	114
Central B	Carmelite House	102	83	35	19	73	2	-48	0***	-48	110
	A.M. Guy Mem'l. Hospital	18	18	17	0	0	1	0	0	0	18
	Botwood	0	0	73	0	0	2	0	73	73	75
	Subtotal	120	101	125	19	73	5	-48	73	25	203
Central C	New facility	0	0	30	0	0	2	0	30	30	32
	Subtotal	0	0	30	0	0	2	0	30	30	32
Central D	North Haven Manor	76	72	74	4	0	2	2	0	2	76
	Notre Dame Bay	15	15	32	0	0	3	0	19	19	35
	Subtotal	91	87	106	4	0	5	2	19	21	111
Central E	Lakeside Homes	123	88	111	35	0	7	23	0	23	118
	Bonnews Lodge	45	35	43	10	0	2	8	0	8	45
	Fogo	0	0	10	0	0	2	0	10	10	12
	Subtotal	168	123	164	45	0	11	31	10	41	175
	Total, Central	491	386	523	104	85	27	8	132	140	635

Table 11.3
(con't)

Region & District	Facility	Total Capacity 1985/86	Level II-III Capacity		Level I Capacity		Respite Recom'd Capacity 1991	Additional Level II-III Beds			Recom'd Capacity 1991 Levels I,II,III & Respite
			1985/86	1991 Recom'd	1985/86	1991 Recom'd		Through Conversion of Level I	Through New Constr'n*	Total	
Eastern Eastern 1A	Dr. W. Templeman Hospital	0	0	12	0	0	0	0	12	12	12
	Subtotal	0	0	12	0	0	0	0	12	12	12
Eastern 1B	Agnes Pratt	66	46	114	20	20	2	0	68	68	136
	Escasoni	191	189	187	2	2	2	0	-2	-2	191
	Glenbrook Lodge	146	104	102	42	42	2	0	-2	-2	146
	Hoyles Home	249	249	247	0	0	2	0	-2	-2	249
	Masonic Park	42	42	40	0	0	2	0	-2	-2	42
	St. Luke's	132	110	108	22	22	2	0	-2	-2	132
	St. Patrick's	214	214	212	0	0	2	0	-2	-2	214
	Subtotal	1040	954	1010	86	86	14	0	56	56	1110
Eastern 2A	Carbonear Interfaith	55	53	53	0	0	2	0	0	0	55
	Harbour Lodge	98	98	146	0	0	2	0	48	48	148
	Pentecostal Home	102	57	46	45	49	0	-7	0	-7	95
	Subtotal	255	208	245	45	49	4	-7	48	41	298
Eastern 2B	Lions Manor	75	75	70	0	0	5	0	-5	-5	75
	Subtotal	75	75	70	0	0	5	0	-5	-5	75

Table 11.3
(con't)

Region & District	Facility	Total Capacity 1985/86	Level II-III Capacity		Level I Capacity		Respite Recom'd Capacity 1991	Additional Level II-III Beds			Recom'd Capacity 1991 Levels I,II,III & Respite
			1985/86	1991 Recom'd	1985/86	1991 Recom'd		Through Conversion of Level I	Through New Constr'n*	Total	
Eastern 3A	Golden Heights Manor	47	46	85	1	0	2	1	38	39	87
	Subtotal	47	46	85	1	0	2	1	38	39	87
Eastern 3B	New Hosp. - Salt Pond	0	0	15	0	0	0	0	15	15	15
	Blue Crest Interfaith	94	68	84	26	8	2	16	0	16	94
	Subtotal	94	68	99	26	8	2	16	15	31	109
Eastern 3C	Dr. G.B. Cross Hospital	0	0	15	0	0	0	0	15	15	15
	New nursing home	0	0	50	0	0	2	0	50	50	52
	Subtotal	0	0	65	0	0	2	0	65	65	67
	Total, Eastern	1511	1351	1586	158	143	29	29	229	239	1758
	GRAND TOTAL	2361	2003	2532-2533	346	253	70-72	76	462-463	538-539	2855-2858

* Includes reallocation from acute care.

** Conversion from Rehabilitation to Level II-III.

*** 15 beds are achieved through new construction but these replace existing beds.

Note: Beds recommended at Burgeo, new facility in Central C, Fogo and Clarenville (new nursing home) may change depending on success of Home Care/Home Support. Numbers should be reviewed before construction occurs.

CHAPTER 12
PRIORITIES

The consultants were asked to identify priorities for the development of facilities and services for acute and long term care. **First and foremost, the Consultants recommend that before any more beds are provided, it is essential to ensure that the beds currently available are being used appropriately. Also Home Care/Home Support services should be well developed throughout the province before providing additional beds as these services may reduce the number of beds required below that indicated as per the norms.**

Based on this, the Consultants have identified priorities in two groups. The first grouping identifies priorities for development of test sites for Home Care/Home Support Services, Level II - III and acute care facilities. The second grouping identifies priorities for the development of level I facilities.

Those areas in which the greatest needs were identified through a combination of deficits to the norm, and information obtained during the consultants visits were given the highest priority. In assigning priorities, consideration was also given to availability of other services and the extent to which level I beds in nursing homes are expected to be reassigned for level II and III care in the future.

In the case of level I services, priorities were based upon the assumption that a maximum of six beds will be licensed in one facility (as recommended by the Royal Commission) and that a limited number of beds will be licensed by the province. Although there is currently no waiting list and there are vacancies in some licensed boarding homes in the province, a limited number of beds have been recommended in order to begin to correct the problem of maldistribution of these beds throughout the province. It should be noted however, that bed numbers shown do not reflect the totals recommended in the regional plans.

Priorities for Development of Home Care/Home Support Level II - III and Acute Care Facilities

Following are the recommended priorities for development of test sites for Home Care/Home Support services, level II - III and acute care facilities.

The priority groups are as follows:

Group I - To be planned and developed as soon as funds are available and before any facilities listed in Group II, III or IV are developed.

Group II - Planning for these facilities should be done concurrently with the development of services in Group I. Construction should begin after services in Group I have been developed and when funds are available.

Group III - Planning for these facilities should be done concurrently (or sooner) with the construction of facilities in Group II. Construction should begin after facilities in Group II have been completed and when funds are available.

Group IV - Planning for these facilities should be done concurrently (or sooner) with the construction of facilities in Group III. Construction should begin after facilities in Group III have been completed and when funds are available.

It should be noted that although reference is made to development of Home Care/Home Support services only in Group I, the Consultants believe that the highest priority in all areas of the province should be development of comprehensive Home Care and Home Support services for both acute and long term care.

Group I

Location	Services/Facilities to be Developed
Burgeo	Pilot Project - Home Care/Home Support services.
Clarenville	Pilot Project - Home Care/Home Support services.
Fogo	Pilot Project - Home Care/Home Support services.
Harbour Breton, St. Albans	Pilot Project - Home Care/Home Support services.

Group II

Location	Services/Facilities to be Developed
Botwood	New nursing home.
Burgeo	New multi-purpose centre.
Corner Brook	Corner Brook Interfaith - conversion to level II - III.
Fogo	New multi-purpose centre.
Grand Bank	Ambulatory care facility with holding beds.
Grand Falls	Carmelite House - redevelopment.
Harbour Breton, St. Albans	New multi-purpose centre.

Group III

Location	Services/Facilities to be Developed
Bonne Bay	New multi-purpose centre.
Clarenville	New nursing home.
Clarke's Beach	Pentecostal Home - redevelopment.
Placentia	New multi-purpose centre.
St. Anthony	St. Anthony Interfaith Home - expansion.

Group IV

Location	Services/Facilities to be Developed
Brookfield	Ambulatory care facilities.
Port Saunders	New health centre.
Twillingate	Notre Dame Bay Memorial Hospital - expansion of level II - III beds.

Priorities for Development of Level I Facilities

As of January 1986, there were a total of 1007 licensed boarding homes in the province or 20 beds per thousand population aged 65 years and over. In addition are the 282 beds in Waterford homes and 346 level I beds located in nursing homes. In total, therefore, there are 1635 beds providing level I care or 33 beds per thousand population 65 years and over.

Although the total number available for level I care is above the recommended norm of 30 beds per thousand population 65 years and over on a province wide basis, there is a significant maldistribution of these beds with the Avalon Peninsula having a substantial surplus and all other areas having a substantial deficit. This is a serious problem as this level of care should be available as close to home as possible for the residents' quality of life. The result of the maldistribution is that persons in need of this care but not living on the Avalon must either move to the Avalon and compromise community and family ties, remain in their community in inappropriate circumstances or enter a nursing home. In the future, the latter option will be less available as nursing homes become more and more occupied by level II and III residents.

The Bed Study has identified those areas of the province in which there are substantial deficits of level I facilities according to the norm. In most areas the Consultants' recommendations have been conservative and at least in the short run, do not bring these areas up to the full capacity allowed by the norm. Because of the apparent oversupply on the Avalon Peninsula (supported by evidence of a substantial number of vacant beds) and because provision of the recommended home care/home support services is expected to reduce the need for level I beds, it is recommended that no additional beds be licensed in the Avalon district until a detailed study has been completed. In fact, based on current information, the number of beds on the Avalon Peninsula should be reduced.

The recommended priorities for development of level I facilities are listed below. The priority groupings are as follows:

Group I	- Highest Priority	- to be provided as soon as funds are available.
Group II	- Second Priority	- to be provided as soon as all facilities in Group I are provided.

Further subdivisions within the groups (a, b, c, etc.) indicate rank order high to low (i.e. a = highest).

Group	**Sub-Group**	**Location**	**Number of Beds***
I	a	Central C District	6
		Fogo	6
		Western B District	12
		Bonne Bay area	6
I	b	Western B District	12
		Baie Verte area	6
		Burin Peninsula	6
		Glovertown - Eastport area	6
I	c	Western B District	6
		Bonavista Peninsula	6
		Subtotal, Group I	72
II	a	Western B District	12
		St. Anthony area	6
		Twillingate area	6
		Bonavista Peninsula	6
II	b	Burin Peninsula	6
		Corner Brook	6
		Glovertown - Eastport	6
		Western B	6
		Subtotal, Group II	54

*** The consultants recommended numbers in accordance with the Royal Commission recommendation of limiting the number of beds to be licensed in a facility to a maximum of six. These recommended priorities are based on the understanding that a limited number of beds will be licensed by the province and do not reflect the totals recommended in regional plans. The beds recommended should be located in the general area indicated, but do not necessarily need to be located in the town named or all in one facility (i.e. 2 homes of 3 beds could make up the total of 6).**

REGIONAL PLANS

There are five Regions in Newfoundland and Labrador which are comprised of a number of health care districts. These districts were used by the consultants as a basis for planning health care services as follows:

1. **Labrador Region** is comprised of two districts:

   Labrador City - Labrador City, Churchill Falls, Wabush.
   Coastal Labrador - Goose Bay/Happy Valley and coastal communities.

2. **Northern Region** is one district comprised of the entire Northern Peninsula of the province.

3. **Western Region** is comprised of two districts:

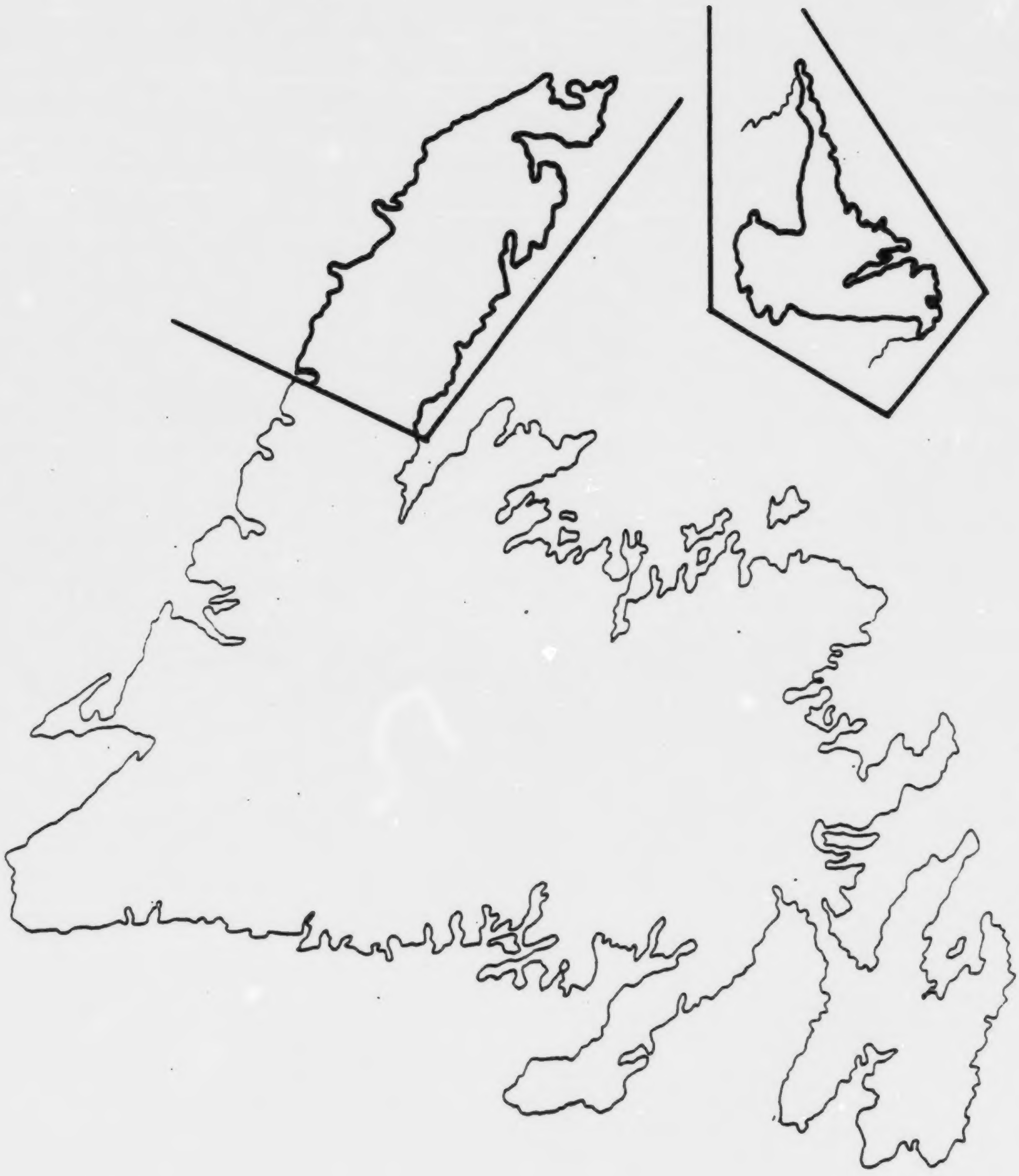
   Western A - Corner Brook, Bonne Bay, Burgeo, Hampden.
   Western B - Stephenville, Channel.

4. **Central Region** is comprised of five districts:

   Central A - Baie Verte, Springdale
   Central B - Grand Falls, Buchans, Botwood
   Central C - Harbour Breton, St. Albans
   Central D - Lewisporte, Twillingate
   Central E - Gander, Fogo, Brookfield

5. **Eastern Region** is comprised of seven districts:

   Eastern 1A - Avalon (includes Bell Island, Conception Bay South, Goulds, Kilbride)
   Eastern 1B - St. John's, Greater St. John's
   Eastern 2A - Bay de Verde Peninsula
   Eastern 2B - Southwestern Avalon
   Eastern 3A - Bonavista Peninsula
   Eastern 3B - Burin Peninsula
   Eastern 3C - Clarenville, Come By Chance



Labrador - Northern

General Description

For purposes of this report, the Labrador and Northern Regions will be considered together in discussing the needs for acute and long term care services. Historically, people from Labrador have traveled to the regional hospital in St. Anthony for selected secondary health care services and there is a very strong association between St. Anthony and the coastal communities south of Cartwright for long term care.

This area includes all of Labrador and the Northern Peninsula of Newfoundland from River of Ponds north on the west coast of the peninsula and Frenchman's Cove north on the east coast of the peninsula. There are three health districts within this area; Coastal Labrador, Labrador City and Northern. The major communities within these districts include Labrador City, Churchill Falls, Wabush, Goose Bay/Happy Valley and St. Anthony. There are many other small communities, particularly along the eastern coast of Labrador.

The planning and provision of health care services is more difficult here than in most other parts of Newfoundland because the communities are isolated, sparsely populated and many are inaccessible by road. In addition, the customs and traditions of caring for the elderly held by the Innu and Innuit of Coastal Labrador make institutional care a less viable option in this area than in many others.

Health Problems

In addition to problems related to diabetes and hypertension experienced by most areas of Newfoundland, this area reports a major problem with mental illness manifested by depression, alcohol and drug abuse and suicide. These problems are of special concern because of the frequency with which they are found in teenagers. Furthermore, these problems frequently go unrecognized and untreated until physical disorders become apparent and admission to a health care facility is necessitated.

Inventory of Health Care Services

The regional hospital for the area is Charles S. Curtis Memorial Hospital in St. Anthony. In addition, there are three community hospitals in these regions. There are several nursing stations located in the smaller communities in the Northern Peninsula and Labrador. There are also two nursing homes and two Licensed Boarding Homes. Following is a description of the services provided:

Labrador City

The Captain William Jackman Hospital in Labrador City, is operated by the Salvation Army and reported 47 beds in operation in 1984/85, broken down as follows: 11 obstetrical beds, 12 pediatric beds and 24 surgical and undistributed beds. The hospital employs one nurse to provide home care in the community with an emphasis on acute/convalescent care although there are a few geriatric patients on her caseload.

Coastal Labrador

Melville Hospital in Goose Bay, is operated by the Grenfell Regional Health Services and reported 51 beds broken down as follows: 29 surgical and undistributed, 10 obstetrical beds, 6 pediatric beds and 6 long term care beds. Patients requiring certain secondary surgical procedures are referred to St. Anthony.

The Harry L. Paddon Memorial Home in Goose Bay, is a 53-bed nursing care facility including one bed which is used for respite, convalescent care and emergency admissions from the community. The Home has an extensive outreach program which provides the following services: home care, homemakers/handyman service, wheels to meals, day care, friendly visiting and visiting seniors in the hospital, dietary advice and other services of a primarily social nature.

Pine Lodge in Happy Valley, is a 10-bed licensed boarding home which provides level one services for its residents, some of whom have psychiatric illnesses and others of whom are just elderly.

There are Nursing Stations at the following locations in Labrador in which a few beds for holding/observation purposes are located:

Location	Beds Reported
Makkovik	4 beds
Hopedale	2 beds
Nain	9 beds
Forteau	4 beds
Cartwright	7 beds (note that the consultants were advised that only 2 beds are in operation)
Mary's Harbour	3 beds

A Home Care Program serving the Labrador South area has been developed as a cooperative effort between the Department of Social Services and the Medical and Nursing staff of the Grenfell Health Services.

St. Anthony

The Charles S. Curtis Memorial Hospital serves as the Regional Hospital for the Labrador and Northern Regions. It reported 146 beds in operation broken down as follows: 24 medical beds, 50 surgical beds, 10 ICU beds, 20 obstetrical beds, 16 psychiatric beds and 26 pediatric beds. Although no beds are designated for long term care, there are approximately five patients requiring such care in the hospital at all times.

St. Anthony Interfaith Home is a 48-bed nursing care facility including one bed for respite. The Home provides limited day care (for 2 - 3 persons), limited wheels to meals and there are 20 senior citizen cottages affiliated with it.

Port Saunders

Port Saunders Hospital is a 16-bed facility which reported the following breakdown of beds: 10 surgical and undistributed beds, 2 obstetrical beds, and 4 pediatric beds. Although no beds were reported for long term care, 3 to 5 beds are occupied at all times by long term care patients.

There are Nursing Stations at the following locations in the Northern Region in which a few beds for holding/observation purposes are located:

Location	Beds Reported
Flowers Cove	2 beds
Roddickton	4 beds

Roddickton

There is a 20 bed licensed boarding home in Roddickton.

Population

The most striking feature of the population of the Labrador and Northern Regions is that it is significantly younger than the rest of the province. Several factors account for this. The first of these is that in the Labrador City Health District, there are almost no elderly residents. This area is totally dependent on the mines and power company in Churchill Falls and when people retire, they leave the area. Therefore, the only elderly here are parents or relatives living with people employed in the area. The second factor is that there is a high birth rate, particularly along the coast of Labrador and finally, the native population, in particular the Innu, do not live to be very old.

Statistics from the 1981 census provided the following information on the population of the Labrador and Northern Regions:

Health District	0 - 14	15 - 64	65 - 74	75 +	Total
Labrador City	5225	9355	80	35	14695
Churchill Falls	350	585	0	0	935
Eastern Labrador	5410	9735	350	195	15690
Subtotal	10985	19675	430	230	31320
St. Anthony	6060	11725	725	355	18865
Total	17045	31400	1155	585	50185

The projected future populations for Labrador and Northern Regions are as follows:

Labrador Region

Year	Total Pop.	0 - 14	% 0 - 14	65 +	% 65 +
1986	30855	9845	31.9	776	2.5
1991	30394	8749	28.8	893	2.9
2001	29211	6913	23.7	1031	3.5

Northern Region

Year	Total Pop.	0 - 14	% 0 - 14	65 +	% 65 +
1986	19726	5677	28.8	1249	6.3
1991	20598	5313	25.8	1418	6.9
2001	19678	4701	23.9	1611	8.2

Assessment of Needs

Acute Care

The guidelines of 3.5 - 4.0 beds per thousand population were considered by the consultants as a useful starting point in determining beds required for acute care. A review of current and anticipated future practices however, indicated that approximately 10% of the services required are of a tertiary nature such as can be obtained only in St. John's. Therefore, the actual guidelines which have been used are 3.15 to 3.60 acute care beds per thousand population (i.e. 10% of beds from each region assigned to St. John's). Pediatric bed requirements (i.e. beds in designated pediatric units) have been determined by applying the norm of 1.125 beds per thousand (as per Pediatric Discussion Paper) to the regional population and have been considered as part of the total requirement for acute care beds.

Application of these guidelines to the populations of Labrador and Northern Regions yields the following numbers:

Labrador

Year	Total Pop.	Acute Care Beds @ 3.15-3.6/ 1000	Pop. 0-14	Ped. Beds @ 1.125/1000	Acute Care Beds Required (excl. Peds)
1986	30855	97 - 111	9845	11	86 - 100
1991	30394	96 - 109	8749	10	86 - 99
2001	29211	92 - 105	6913	8	84 - 97

Northern

Year	Total Pop.	Acute Care Beds @ 3.15-3.6/ 1000	Pop. 0-14	Ped. Beds @ 1.125/1000	Acute Care Beds Required (excl. Peds)
1986	19726	62 - 71	5677	6	56 - 65
1991	20598	65 - 74	5313	6	59 - 68
2001	29211	62 - 71	4701	5	56 - 65

Currently there are 94 acute care beds (including 10 pediatric beds) available in the two hospitals in Labrador (Note that the beds in the Nursing Stations are not included in the inventory of acute care beds in Labrador and/or Northern Region). This figure is based on beds which were staffed and in operation at the time of the consultants visits to the hospitals, not on beds reported in the Annual Returns to the Department of Health. Therefore, based on strict application of the guidelines, there is an appropriate number of acute care beds both for adults and pediatrics in this Region.

In the Northern Region however, there is a significant surplus of acute care beds. There are 130 acute care beds in the hospitals in St. Anthony and Port Saunders compared to the 62 - 71 recommended by the guidelines.

A discussion regarding patterns of practice, bed utilization and specific recommendations by hospital within these regions is presented later in this report.

Rehabilitation

As indicated earlier in this report, there is a shortage of rehabilitation beds and services throughout Newfoundland and Labrador. There are no rehabilitation beds located in the Northern and Labrador Regions and access to beds at the Miller Center in St. John's is very limited.

Application of the recommended guideline of 0.2 beds per thousand population to the projected population of the Labrador and Northern Regions yields a requirement for 10 beds.

Long Term Care

Labrador

As previously discussed, the population of Labrador, and in particular, the Labrador City, Churchill Falls districts, is much younger than the rest of the province, therefore, the needs for long term care services are much less. Even within Labrador, the needs vary considerably, therefore, the needs will be discussed by long term care district (rather than in relation to the whole region), the first of which includes Labrador City, Churchill Falls and Wabush.

The 1981 census population of this area was as follows:

Health District	0 - 14	15 - 64	65 - 74	75 +	Total
Labrador City	5225	9355	80	35	14695
Churchill Falls	350	585	0	0	935
Total	5575	9940	80	35	15630

In 1981, the percentage of the population which was 65 years and over in this district was much lower than the provincial average (.7% compared to 7.7%). This is projected to continue into 2001 and the requirement for long term care services reflects this situation.

Projections to 1991 and 2001 provided by the Royal Commission for the Labrador area were broken down into health districts by the consultants. The projected future population for the Labrador City, Churchill Falls, Wabush area is as follows:

Year	Total Population	Population 65 +	% 65 +
1986	15399	141	.9
1991	15168	168	1.1
2001	14578	192	1.3

Based on this population information and on information gathered from Public Health Nurses and other health care personnel, there is no need for the development of nursing home beds or other long term care services now or in the foreseeable future in this district.

Coastal Labrador

This district includes Goose Bay/Happy Valley and the communities along the coast of Labrador. The consultants have been advised, however, that for the purposes of calculating requirements for institutional beds for long term care in this area, the population of the coastal communities south of Cartwright should be excluded from this district and included in the Northern region. The rationale for this is that people from these communities have historically gone to St. Anthony for many other services including acute medical services. Consequently, the total population figures and the 65 years and over population figures shown below exclude the population of all coastal communities south of Cartwright.

The 1981 census population of this area was as follows:

Health District	0 - 14	15 - 64	65 - 74	75 +	Total
Coastal Labrador	3474	6252	226	125	10077

The projected future population of Coastal Labrador is as follows:

Year	Total Population	Population 65 +	% 65 +
1986	9928	408	4.1
1991	9779	466	4.8
2001	9398	540	5.7

Application of the guidelines of 40 beds per thousand population 65 and over for level II and III care and 30 beds per thousand for level I care to the area population and projected population yields the following numbers:

Year	Population 65 +	Level II & III Beds @ 40/1000	Level I Beds @ 30/1000
1986	408	16	12
1991	466	19	14

Currently, there are 46 beds in use for level II and III care at Harry L. Paddon Memorial Home, therefore, there is a surplus of 30 beds based on the norm. There are currently 6 level I beds at Paddon Memorial and 10 level I beds at Pine Lodge for a total of 16 beds, yielding a surplus of 4 beds according to the norm for level I care.

Results of surveys completed by public health nurses and district social services offices yielded the following information:

ESTIMATED NUMBERS IN NEED OF THE FOLLOWING SERVICES

District	Nursing Home		Boarding Home		Home Care	
	S. Serv.	PHN	S. Serv.	PHN	S. Serv.	PHN
Happy Valley	5	5	3	22	8	3
Cartwright	0	0	0	1	0	0
Davis Inlet	0	0	0	0	3	(no # provided)
Forteau	0	16	0	3	30	92
Hopedale	1	*	0	*	0	*
Mary's Harbour	2	*	0	*	2	*
Nain	1	1	1	1	2	8
Sheshatshiu	0	*	1	*	5	*
Pt. Hope Simpson	*	1	*	1	*	5
Black Tickle	*	0	*	0	*	(no # provided)
Northwest River	*	0	*	1	*	2
Postville	*	0	*	0	*	0
Makkovik	*	1	*	1	*	0
Total	9	24	5	30	50	110+

* Indicates that no information was received because survey was not returned, office is vacant, or no office in a particular community.

Harry L. Paddon Memorial Home provided the following information on applicants awaiting admission to that facility:

NUMBER ON WAITING LIST* BY LEVEL AND LOCATION

Level	Hospital	Other Nsg Home	Home of Relative/ Friend	Own Home/ Sr. Cit. Apt.	Boarding Home	Total
III	1	0	0	0	0	1
II	0	0	1	0	0	1
I	0	0	2	2	0	4
Total	1	0	3	2	0	6

* Waiting lists do not necessarily accurately reflect those in "need" of nursing home care.

Northern

The Northern District encompasses the entire Northern Peninsula and, as previously discussed, for the purposes of calculating requirements for long term care beds, the population of the coastal communities of Labrador south of Cartwright. Consequently, the total population figures and the 65 years and over figures shown below include the population of these areas in addition to the Northern region.

Population

The 1981 census population of this area was as follows:

Health District	0 - 14	15 - 64	65 - 74	75 +	Total
Northern	6060	11725	725	355	18865
Portion of Pop.* Coastal Labrador South of Cartwright	1936	3483	124	70	5613
Total	7996	15208	849	425	24478

* Calculated by Statistics Canada census division and subdivision.

The projected future populations for the Northern Region and for the communities of Coastal Labrador south of Cartwright are as follows:

Year	Total Population	Population 65 +	% 65 +
1986	25256	1476	5.8
1991	26045	1667	6.4
2001	24911	1911	7.6

In 1981, 5.7% of the population of the Northern Region was aged 65 years and over compared to the provincial average of 7.7%. Projections as shown above indicate that this area will continue to have a lower percentage of elderly than the provincial average of 10.9% by 2001. Recommendations regarding the number of beds required in this region reflect this.

Newfoundland Bed Study - 8514

Application of the guidelines of 40 beds per thousand population 65 and over for level II and III care and 30 beds per thousand for level I care to the area population and projected population yields the following numbers:

Year	Population 65 +	Level II & III Beds @ 40/1000	Level I Beds @ 30/1000
1986	1476	59	44
1991	1667	67	50

There are 36 beds in use for level II and III residents at St. Anthony Interfaith, therefore there is a current deficit of 23 beds based on the norm. There are currently 12 level I beds at St. Anthony Interfaith and 20 beds in a licensed Boarding Home in Roddickton for a total of 32, yielding a deficit of 12 beds according to the norm for level I care.

Results of surveys completed by public health nurses and district social services offices yielded the following information:

ESTIMATED NUMBERS IN NEED OF THE FOLLOWING SERVICES

District	Nursing Home		Boarding Home		Home Care	
	S. Serv.	PHN	S. Serv.	PHN	S. Serv.	PHN
St. Anthony	3	12	0	1	52	35
Port Saunders	2	5	10	0	65	2
Flowers Cove	6	4	0	4	0	34
Roddickton/Englee	1	5	4	3	2	8
Harbour Deep	*	*	*	*	*	*
Total	12	26	14	8	119	79

* Indicates that no information was received because survey was not returned, office is vacant, or no office in a particular community.

St. Anthony Interfaith Home provided the following information on applicants awaiting admission to that facility:

NUMBER ON WAITING LIST* BY LEVEL & LOCATION

Level	Hospital	Other Nsg Home	Home of Relative/ Friend	Own Home/ Sr. Cit. Apt.	Boarding Home	Total
III	0	4	7	0	0	11
II	0	0	10	0	0	10
I	0	10	10	0	0	20
Total	0	14	27	0	0	41

* Waiting lists do not necessarily accurately reflect those in "need" of nursing home care.

Discussion & Recommendations

Labrador

Labrador City

The Captain William Jackman Hospital currently has excess capacity, reports low patient days and correspondingly low utilization, particularly in Pediatrics and Obstetrics. The consultants have been advised however, that the Pediatric unit reported as 12 beds has been closed and that 4 Pediatric beds have been relocated to a room on the surgical unit.

The obstetrical unit is significantly oversized. There are 11 beds but 5 beds would handle the approximately 175 deliveries per year as well as the projected workload. Relocation of the labour/delivery suite into the obstetrical unit would improve operating efficiency, however due to the lack of appropriate medical gases, to accomplish this relocation, the entire medical gas system in the hospital would have to be upgraded. This would be a costly effort.

Itinerant surgery in this hospital leads to volatile occupancy rates which, at times, necessitates occupancy of obstetrical beds by surgical patients. As a result, no change in bed numbers in the short term is recommended. If and when it is possible to relocate labour/delivery adjacent to the postpartum unit, obstetrical beds should be reduced by 5 or 6.

Goose Bay/Happy Valley and Coastal Labrador

Home Care/Home Support Services

The major requirement in Coastal Labrador is for development of comprehensive home care services to meet the needs of those with chronic illnesses and/or impairments. With this in mind, the following specific recommendations are made:

1. Comprehensive home care/home support services should be coordinated by and provided through Harry L. Paddon Memorial Home.

2. The consultants are aware that limited Home Care services are currently being provided to residents of the Labrador South area through a cooperative effort between Social Services and the Grenfell Regional Health Services. It is recommended that these services be expanded to provide a more comprehensive program (i.e. Home Support too) and that they be extended to residents of more northerly coastal communities. This is particularly important in view of the fact that many people, especially the Innu and Innuit are very reluctant or refuse to leave their communities even when their health deteriorates to the point that institutional care may be required. It is suggested that non professional persons in each of the communities be trained to provide home nursing services under the supervision of a professional (i.e. Public Health Nurses or Primary Nurses from the Health Centre). Alternatively, consideration could be given to co-ordination and organization of these services through Harry L. Paddon Memorial Home, since this facility seems to be viewed as the major resource center for Long Term Care in this district and since it currently is involved in the provision of home care.

   Home handyman services in Coastal Labrador communities are also extremely important. This was emphasized in the regional meeting held in Happy Valley and by Public Health Nurses and Social Services personnel surveyed by the consultants. Basic needs for fire wood, drinking water and for waste disposal for many elderly must be met if they are to be able to remain in their own homes. Addressing these needs will require cooperation among a number of Government Departments.

Goose Bay - Happy Valley

Melville Hospital

Since closure of the hospital in North West River, the utilization of beds at Melville Hospital has increased. The major problem faced by this hospital is overcrowding in patient rooms such that there are three beds in some two-bed rooms. In addition there is a lack of space in the Ambulatory clinic area of the hospital. There is however, a considerable amount of space available in other areas of this hospital, therefore it is recommended that in the short run, internal renovations be carried out to address both of these problems. If, in the future, there is pressure for more beds, consideration could be given to increased usage of hostel facilities by women who are now admitted for a period of time antenatally awaiting delivery.

It is also recommended that the designated Pediatric unit for the Labrador Region be located here and that there be 6 beds in this unit. As discussed previously, the population base exists in this area to justify up to 11 pediatric beds (as per 1.125 beds/1000 aged 0-14). However, due to the fact that the current (1984/85) pediatric utilization rate at this facility is 63%, it suggests that 6 beds is adequate. Also, it is recognized that some children from the coastal communities of Southern Labrador are referred to St. Anthony for acute care. As a result, the other 5 beds should be allocated to the Northern Region where a designated pediatric unit should be established at Curtis Memorial Hospital.

Nursing Stations

Makkovik

The facility reported 4 beds and 35 patient days for a total occupancy rate of 2.4% in 1984/85. Since closure of beds would accomplish little, no changes are recommended.

Hopedale

This facility reported 2 beds and 62 patient days for a total occupancy rate of 8.5% in 1984/85. No change in the number of beds is recommended, however this facility should be replaced.

Nain

This facility reported 9 beds and 603 patient days for a total occupancy rate of 18.4% in 1984/85. Due to the isolation and extreme weather experienced in this area, no change in the number of beds is recommended.

Forteau

This facility reported 4 beds and 483 patient days for a total occupancy rate of 33.1% in 1984/85. Two beds is adequate to meet the need for short term holding and observation beds in this area, therefore no change is recommended.

Cartwright

This facility reported 7 beds and 44 patient days for a total occupancy rate of 1.7% in 1984/85. The consultants have been advised that this facility has recently been renovated and now has two beds which should meet the needs in this area. No change is recommended.

Mary's Harbour

This facility reported 3 beds and 21 patient days for a total occupancy rate of 1.9% in 1984/85. No change is recommended.

Harry L. Paddon Memorial Home

At present, no additional beds for levels I, II or III care are needed in this district, nor is there projected to be a need by 1991. Additional nursing, physiotherapy and occupational therapy staff however are required to meet the needs of residents of Harry L. Paddon Memorial Home and to provide support to seniors living in the community who are receiving services at the Home. Should additional physiotherapists and/or occupational therapists be obtained, they could also provide services to those receiving home care now and perhaps in future to those in coastal communities when home care services are developed.

Expansion of physical facilities to accommodate physiotherapy and occupational therapy activities should be considered.

Other Facilities

Transition House/Group Home

A transition house/group home should be developed in the Goose Bay/Happy Valley area to provide supervised housing in a structured living environment for approximately five persons from this area who have psychiatric illnesses. These persons are frequently admitted to Melville Hospital, transferred to the Waterford Hospital, discharged to unstable living situations where their conditions deteriorate and then are readmitted to hospital and so on.

Note: Although it is outside the mandate of this study to comment on housing conditions, it should be noted that repeated concerns have been identified regarding the very poor housing conditions under which many of the elderly throughout this district were living. Based on these concerns, it may be appropriate to undertake a study to determine the extent of the problem and what, if any action is required.

Northern

Home Care/Home Support Services

Development of a program for comprehensive home care/home support throughout the Northern Region to provide consistent, continuous services including nursing services, basic assistance with activities of daily living and upkeep of home (i.e. cleaning, shoveling, etc.) should be considered a priority.

St. Anthony

Despite the fact that there are twice as many acute care beds in this area as would be recommended using the guidelines of 3.15 - 3.60 beds per thousand, the occupancy rates at Curtis Memorial Hospital are still high, particularly in medicine and surgery (1984/85 81.3% medicine, 97.3% surgery). Occupancy of obstetrical beds as reported in the Annual Return for 1984/85 was 48.5%. Although on the face of it, this does not seem high in view of reported newborn patient days for 1984/85 (1,973), the reported obstetrical patient days (3,538) seem higher than they should be. If it can be assumed that an average length of stay for a newborn is 5 days and that for normal deliveries most women should be in hospital an average of 6 days, it could be expected that obstetrical days would be about 20% higher than newborn days. Since Curtis Memorial is the regional hospital and has obstetrical specialists, it is reasonable to assume that at least some women would be admitted for a period of time antenatally due to complications of pregnancy and that as a result, obstetrical days would increase. However for 1984/85, reported obstetrical days were 79.3% higher than newborn days. This strongly suggests that a significant number of expectant mothers are admitted to the hospital antenatally to await delivery, at least a portion of whom could be accommodated easily in hostel facilities if they were available.

Hostel facilities may also be appropriate for pediatrics and the use of hostel beds in combination with better organized preadmission diagnostic testing services would probably reduce medical - surgical patient days. The Executive Director of the Grenfell Services felt that approximately 5 - 10% of all patient days in the hospital could be eliminated if a hostel was available. He also felt that further reductions in length of stay were possible.

Although there are no formally designated long term care beds in this hospital, the consultants were advised that approximately 5 beds are occupied by long term care patients at all times. When additional beds are provided at St. Anthony Interfaith Home, these beds should be able to be closed.

In view of the preceding, the following recommendations regarding Curtis Memorial are made:

1. Development of hostel facilities should be considered a priority to facilitate a reduction in medical, surgical, obstetrical and perhaps pediatric patient days.

2. When hostel facilities are available, consideration should be given to reducing obstetrical beds to 10 - 15. This would represent a reduction of 5 - 10 beds.

3. A designated pediatric unit of 12 - 15 beds to serve the Northern Region and part of Coastal Labrador should be established. The Northern Region can support 6 beds (as per the guideline of 1.125 beds per 1000 population 0-14), and as previously discussed, 5 beds justified by the population of Labrador can reasonably be allocated here. This would represent a reduction of 11 - 14 beds.

4. If the assumption that hostel facilities combined with improved preadmission diagnostic testing and reductions in lengths of stay could produce at least a 10% reduction in medical surgical patient days is correct, based on reported medical surgical patient days for 1984/85 (24877), at 100% occupancy, 7 beds could be closed (or 8 beds at 85% occupancy).

5. A 10 bed rehabilitation unit should be established to serve the Northern Region and the population of Labrador. According to the Executive Director, space in the hospital could be renovated without a great deal of difficulty to provide suitable facilities for an inpatient Rehabilitation unit. However, space for appropriate outpatient Rehabilitation services would be more difficult, although not impossible, to develop. The emphasis of this unit would be on slow paced rehabilitation for stroke victims and others who would benefit most from such care. The presence of this unit may also facilitate earlier discharge of some patients from the Miller Unit. It is anticipated that an important part of the Unit would be a very active community outreach program which could extend to areas such as Roddickton, Flowers Cove, Port Saunders and others. Additional physiotherapy and occupational therapy staff would be required and perhaps a Speech Therapist as well. These staff could be shared with St. Anthony Interfaith, the residents of which would undoubtedly benefit greatly from such services.

6. There is a need for improved Psychiatric and Mental Health services in both the Labrador and Northern Regions. It should be noted that the 16 Psychiatric beds are only staffed 16 hours per day. Psychiatric inpatients, of whom there are usually 6, sleep on the medical floor at night. No change is recommended regarding psychiatric services at the hospital until the Provincial plan for psychiatric services has been developed.

In summary, it appears that there is potential to reduce the number of beds at Curtis Memorial Hospital over time from 134 to between 100 and 110 (including the 10 beds for Rehabilitation) and perhaps lower in future. Due to the isolation of the communities served by this hospital however, the number of beds which will be provided will probably remain above that which would be recommended according to the guideline of 3.15 - 3.60 beds per thousand population. Target numbers will be highly dependent upon several factors including improvements in transporation, the success of Home Care services, and changes in medical referral patterns in the Region which can only be evaluated over time.

Other Services

There is a need to develop additional long term care services to meet the needs of the residents of the Northern region and the Coastal area of Southern Labrador. Such services should include construction of additional nursing home beds and development of comprehensive home care services. Specific recommendations follow:

An additional 20 - 24 beds, and facilities appropriate for occupational and physiotherapy activities should be constructed at St. Anthony Interfaith Home. Ten to twelve of these beds at a minimum, should be designed for old age psychiatric care. As many as possible of the 12 beds currently used for level I care should be converted for level II and III care to meet requirements for heavier nursing care for the next five years.

Two beds (in addition to the beds recommended above) should be formally designated for respite care, short term emergency admissions and convalescent care at St. Anthony Interfaith.

The need for expansion of Wheels to Meals and Day Care services currently provided by St. Anthony Interfaith should be evaluated. Apparently both of these services are underutilized which may suggest that there is an expectation and/or preference for services to be provided in the home rather than going out for services.

Level I Facilities

Over the next few years, 20 - 26 level I beds should be developed in the Northern Region through licensing of Personal Care Homes or development of a congregate living facility. These facilities should be closely associated with the Nursing Home.

Port Saunders

Port Saunders Hospital reported 16 beds and 2738 patient days for a total occupancy rate of 46.9%. Although there are no beds formally designated for long term care, 3 - 5 beds are occupied at all times by patients requiring long term care.

Port Saunders Hospital, although relatively new and well maintained, is inappropriate for either acute care or long term care. It is of residential construction, is poorly laid out and is not wheelchair accessible. It is situated on a windy, steep hill and receives a great deal of blowing snow in winter.

There is considerable pressure from individuals in the Port Saunders area to develop long term care services here. Concern was expressed regarding the erosion of the extended family as a result of more and more women entering the work force. Because of this, people from this community feel that the development of home care services may not be as appropriate in this area, as in other areas of the province. Rather, it is felt by people of this community, that sheltered housing, including senior citizens cottages and licensed boarding facilities as well as nursing home beds should be provided in the Port Saunders area. Their central location (halfway between St. Anthony and Corner Brook) was cited as one reason why it would make sense to develop such facilities here.

Given that the hospital is unsuitable for the provision of long term care and that it is not well suited, because of the residential nature of its construction, for acute care, it is suggested that in the long term, consideration be given to the construction of a facility to provide four beds for holding/observation purposes and space for ambulatory clinics, similar to that at Flowers Cove.

In the long term, it is recommended that consideration be given to the development of a licensed boarding facility or a congregate living facility to provide 6 - 12 level I beds in this area. This should only be done if the number of beds in the hospital are reduced as discussed above.

Flowers Cove

The Health Centre in Flowers Cove reported 2 beds and 28 patient days for a total occupancy rate of 3.8% in 1984/85. No change is recommended.

Roddickton

The Health Centre in Roddickton reported 4 beds and 307 patient days for a total occupancy rate of 21% in 1984/85. This facility should be replaced by one similar to that located in Flowers Cove where there are two beds.

Other Comments

The recommendations regarding the number of level I beds that should be developed in the Northern Region are based upon the assumption that 8 of the 12 beds now in use at St. Anthony Interfaith for level I care could be converted to level II - III care. While this is undoubtedly possible, it will require renovations to provide appropriate nursing stations and support facilities.

Note: Recommendations regarding the total number of nursing home beds to be developed in this region were based upon strict application of the norm of beds 40 per thousand population 65 and over. Due to the extreme isolation of many of the communities in this region (and especially those in Coastal Labrador) however, the development of adequate and appropriate home care services may be somewhat limited. Consideration should therefore be given to increasing the bed numbers recommended as per the norm to ensure adequate long term care services are provided.

Labrador and Northern Regions

SUMMARY OF PRESENT CAPACITY* AND RECOMMENDED CAPACITY**

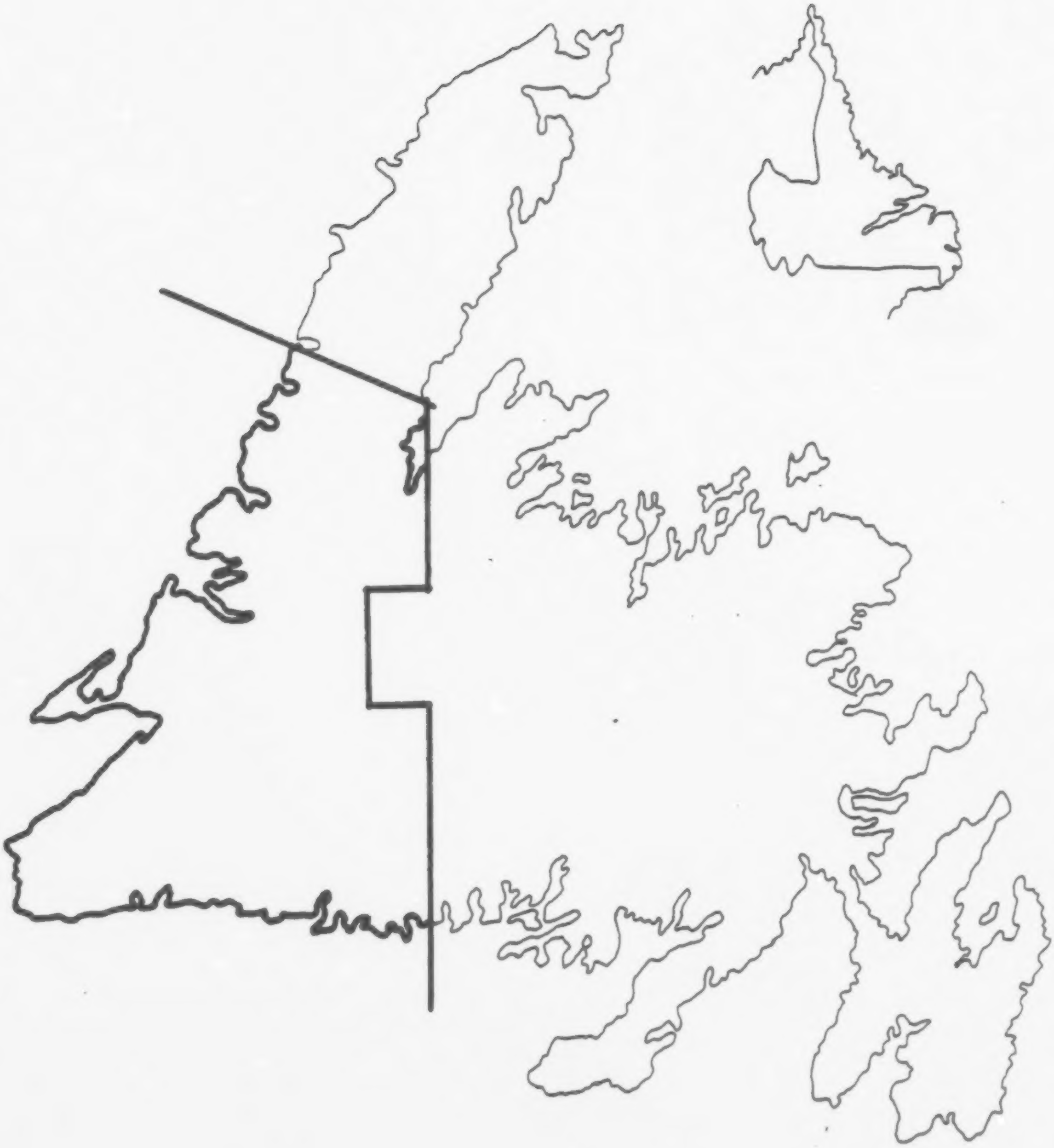
Region/Facility	Total Capacity (1985/86)	Recommended Capacity				
		Acute (2001)	Rehab (1991)	Level II & III (1991)	Level I (1991)	Respite*** (1991)
Labrador						
Captain Wm Jackman Hospital	43	43				
Melville Hospital	45****	45				
Harry L. Paddon Memorial Home	53			46	6	1
Personal Care	10				10	
Total		88	0	46	16	1
(Present Total Capacity)		(88)	(0)	(46)	(16)	(1)
Northern						
Curtis Memorial Hospital	134	90-100	10			
Port Saunders Hospital	16	4				
St. Anthony Interfaith	48			64-68	4	2
Personal Care	20				40	
Total Recom'd Capacity		94-104	10	64-68	44	2
(Present Total Capacity)		(162)	(0)	(36)	(32)	(0)

* Present capacity based upon beds open at time of Consultants visit or on information received since visit.

** Designated holding/observation beds are excluded.

*** Includes convalescent and emergency use.

**** Excludes 6 long term care beds.



Western

General Description

The Western Region is comprised of the following Newfoundland and Labrador Health Districts: Bonne Bay, Burgeo, Hampden, Corner Brook, Stephenville and Channel. The boundaries of this region extend from Channel/Port aux Basques as far north as Bateau Cove on the western boundary and on the eastern boundary from Francois on the south as far north as Jacksons Arm.

The major communities within these districts include Corner Brook, Stephenville, Channel and Bonne Bay. There are several very isolated communities in the Western Region particularly along the south coast.

Health Problems

The health problems in this area are similar to those in the rest of Newfoundland, with diabetes, hypertension and other cardiovascular problems rating among the most frequent reasons for admission to hospital and nursing homes. In addition, alcohol related problems are common.

Inventory of Services

The regional hospital for this area is Western Memorial Hospital in Corner Brook. There are four community hospitals, four facilities providing long term nursing care and six licensed boarding homes in this region. Following is a summary of the services available:

Western A - Bonne Bay, Burgeo, Hampden, Corner Brook

Bonne Bay

Bonne Bay Hospital is operated under the auspices of the Western Memorial Hospital Board. This facility reported 20 medical beds in operation during 1984/85. Although no beds are formally designated for long term care, 5 - 6 beds are occupied full time by patients who require long term care. An additional 6 - 7 patients from this area are regularly admitted to the hospital for respite care, for treatment of chronic conditions and/or because of acute exacerbations.

Burgeo

Burgeo Hospital is a cottage hospital operated under the auspices of the Western Memorial Hospital Board. This facility reported 18 beds, 2 of which were pediatric and the rest surgical and undistributed. One to two beds are provided for respite care on an informal basis.

Corner Brook

Western Memorial Regional Hospital reported 297 beds broken down as follows: 50 medical beds, 114 surgical beds, 15 ICU beds, 29 obstetrical beds, 36 psychiatric beds, 25 pediatric beds and 30 long term beds (15 of these beds are for the care of elderly persons with psychiatric illnesses).

In addition, a 60 bed special care unit is operated by the hospital in the old hospital building. Eight of these 60 beds are for rehabilitation, particularly for stroke patients. The hospital also runs a home care program through purchased services from V.O.N.; a day hospital for 35 people through the Special Care Unit, respite at the Special Care Unit and a Meals on Wheels program.

Corner Brook Interfaith Home is a 102 bed nursing care facility which provides levels I, II and III care although it admits only level I patients. This Home does not accept patients under 64 - 65 years nor will they accept anyone with a mental illness or the mental or physically handicapped.

There are also 92 Senior Citizens Cottages associated with Corner Brook Interfaith Home.

There are four licensed boarding homes in the Corner Brook area which provide a total of 31 beds for level I care. Xavier House, which provides 18 of these beds, is a non profit home run by four Catholic nuns. It is the only non profit personal care facility in the province and is a pilot project funded through the local Social Services Department.

Other Areas

There is a 20 bed licensed boarding home in Deer Lake.

Western B - Stephenville - Channel

Stephenville - Stephenville Crossing

Sir Thomas Roddick Hospital in Stephenville reported 89 beds broken down as follows: 27 medical beds, 26 surgical beds, 14 obstetrical beds and 22 pediatric beds. Although no long term care beds were reported, a 16 bed ward has been converted to accommodate a number of long term care patients who were in the hospital. It is anticipated that when the 50 bed addition to Bay St. George Senior Citizens Home is completed, these patients will be accommodated there. Beds for respite care are provided on occasion at the hospital.

Bay St. George Senior Citizens Home in Stephenville Crossing has 86 beds for level I, II and III care and a 50 bed addition for levels II and III and psychiatric services for the elderly is currently under construction. There are 30 Senior Citizens Cottages adjacent to, and administered by the Home. A meals on wheels program is run three times weekly by the Home and it is hoped that this service may be expanded in future.

A study to assess the requirements for long term care in the area is being conducted by a staff member from the Home and very recently a staff nurse from the hospital in Stephenville was seconded to work with her to study the need for, and plan a Home Care Program oriented towards meeting both acute and long term care requirements in the area. It is also hoped that in the very near future, formalized respite beds will be available at the Home.

Channel

The Charles L. LeGrow Health Centre in Channel reported 40 beds broken down as follows: 35 surgical and undistributed beds and 5 pediatric beds. However the consultants have been advised that at present, there are 20 acute care beds, 16 beds for level 3 care and 2 beds for respite in operation.

A Home Care program is operated by the hospital. It also provides Day Care, which has capacity for about 40 persons. Although the primary focus of the Day Care is socialization, those attending have access to all hospital services they may require, i.e. physiotherapy, lab, etc.

There are 20 Senior Citizens Cottages in Channel operated by the hospital.

Other Areas

There is a 3 bed licensed boarding home in Cape Anguille and a 4 bed licensed boarding home in Piccadilly.

Population

Statistics from the 1981 census provided the following information on the population of the Western Region:

Health District	0 - 14	15 - 64	65 - 74	75 +	Total
Western A Bonne Bay, Burgeo Hampden, Corner Brook	17320	37220	2520	1320	58380
Western B Stephenville, Channel	11985	23815	1565	825	38190
Total	29305	61035	4085	2145	96570

In 1981, the percentage of the population of this area which was 65 years and over was just slightly less than the provincial average (6.5% compared to 7.7%). Projections to 2001 indicate that this trend will continue with the provincial average projected to be 10.9% while the percentage of the elderly in this area is projected to be 9.1%. The number of beds required for long term care in this area therefore will be somewhat less than areas where the percentage of elderly is higher.

The projected future populations for Western Region are as follows:

Western Region

Year	Total Pop.	0 - 14	% 0 - 14	65 +	% 65 +
1986	97226	26654	27.4	7207	7.4
1991	97882	24237	24.8	8185	8.4
2001	100542	20108	19.9	9151	9.1

Assessment of Needs

Acute Care

The guidelines of 3.5 - 4.0 beds per thousand were considered by the consultants as a useful starting point in determining beds required for acute care. A review of current and anticipated future practices however, indicated that approximately 10% of the services required are of a tertiary nature such as can be obtained only in St. John's. Therefore, the actual guidelines which have been used are 3.15 to 3.60 acute care beds per thousand population (i.e. 10% of beds from each region assigned to St. John's). Pediatric bed requirements (i.e. beds in designated pediatric units) have been determined by applying the norm of 1.125 beds per thousand (as per Pediatric Discussion Paper) to the regional population and have been considered as part of the total requirement for acute care beds.

Application of these guidelines to the population of the Western Region yields the following numbers:

Year	Total Pop.	Acute Care Beds @ 3.15-3.60/1000	Pop. 0 - 14	Ped Beds @ 1.125/1000	Acute Care Beds Req'd (excl Peds)
1986	97226	306 - 350	26654	30	276 - 320
1991	97882	308 - 352	24237	27	281 - 325
2001	100542	317 - 362	20108	23	294 - 339

Currently there are 412* acute care beds, including 62 pediatric beds available in the five hospitals in the Western Region. This figure is based on beds which were staffed and in operation at the time of the consultants visits to the hospitals, or on subsequent information received by the consultants, rather than on beds reported in the Annual Returns to the Department of Health. Therefore based on strict application of the guidelines, there is an excess of adult care and pediatric beds in this region. A discussion regarding patterns of practice, bed utilization and specific recommendations by hospital within the region is presented later in this report.

Rehabilitation

As indicated earlier in this report, there is a shortage of rehabilitation beds and services throughout Newfoundland and Labrador. There are only eight rehabilitation beds located in Western Newfoundland and access to beds at the Miller Centre in St. John's is very limited. Applying the norm of .2 beds per thousand population to the 1986 population of the Western region and the population of Central A - Baie Verte - Springdale (as patients from this area are currently referred to Corner Brook for rehabilitation services) yields a requirements for 24 beds in 1986. No additional beds should be required in the future.

Long Term Care

Western A - Bonne Bay, Burgeo, Hampden, Corner Brook

The 1981 census population of this area was as follows:

Health District	0 - 14	15 - 64	65 - 74	75 +	Total
Bonne Bay	2200	4175	335	160	6870
Burgeo	1570	2765	170	105	4610
Hampden	945	1515	85	55	2600
Corner Brook	12605	28765	1930	1000	44300
Total	17320	37220	2520	1320	58380

* Note: This figure includes 16 beds temporarily in use for long term care at Sir Thomas Roddick Hospital.

Newfoundland Bed Study - 8514

Projections to 1991 and 2001 provided for the Royal Commission for Western Newfoundland were broken down into health districts by the consultants. The projected future populations for the Bonne Bay, Burgeo, Hampden and Corner Brook areas are as follows:

Year	Total Population	Population 65 +	% 65 +
1986	59131	4462	7.5
1991	59882	5085	8.5
2001	62542	5691	9.1

Application of the guidelines of 40 beds per thousand population 65 and over for level II and III care and 30 beds per thousand level I care to the area population and projected population yields the following numbers:

Year	*Population 65 +	Level II & III Beds @ 40/1000	Level I Beds @ 30/1000
1986	4462	178	134
1991	5085	203	153

* Note that the population of the Burgeo - Ramea area and the adjacent coastal communities from Grand Bruit to Francois should be included in the Western A region for the calculation of long term care bed requirements only if facilities for such care are developed in that area (i.e. Burgeo). If this is not done, the population of this area should be subtracted from the Western A region and added to the Western B region since the consultants were advised that this is where the majority of the elderly would prefer to go if they cannot obtain long term care services in their own area.

Currently there are 51 beds in use at Corner Brook Interfaith and 52 beds in use at the Western Memorial Special Care Unit for levels II and III care. (Note that this does not include the 30 bed unit at Western Memorial). Thus there is currently a deficit of 75 beds. There are currently 51 beds in use at Corner Brook Interfaith for level I care and an additional 51 beds available in Boarding Homes in the area. A deficit of 32 level I beds is therefore currently experienced in this area.

Results of a survey completed by public health nurses and district social services offices yielded the following information:

ESTIMATED NUMBER IN NEED OF THE FOLLOWING SERVICES

District	Nursing Home		Boarding Home		Home Care	
	S. Serv.	PHN	S. Serv.	PHN	S. Serv.	PHN
Corner Brook	15	4	10	20	40	88
Deer Lake	5	0	2	4	6	15
Bonne Bay	*	10	*	0	*	3
Burgeo/Ramea	2	2	0	1	3	21
Cow Head	*	0	*	0	*	6
Hampden	*	0	*	0	*	3
Pasadena	*	8	*	4	*	14
Benoits Cove	*	0	*	0	*	6
Meadows	*	0	*	0	*	11
Total	22	24	12	29	49	167

Note: The numbers indicated by PHN from Corner Brook included a response from a V.O.N. nurse who provides Home Care services and whose estimates were as follows: 1 needing nursing home, 19 needing boarding home, and 80 needing home care.

* Indicates that no information was received because survey was not returned, office vacant, or no office in a particular community.

As noted in other areas of the province, there is a substantial discrepancy in the assessment of need for boarding home and home care services between social services workers and public health nurses. It is particularly interesting to note however, that the two groups agree on the numbers needing nursing home placement and that this number is substantially lower than would be expected from the deficit of these services in comparison to what the norm of 40/1000 65 years and over would suggest. Part of this discrepancy may be explained by the fact that the 30 medically discharged patients in the chronic care unit of Western Memorial are not included in the inventory of beds available nor would they likely have been included by the PHN's and social services workers in their assessment of those in need of placement.

Corner Brook Interfaith Home provided the following information on applicants awaiting admission to that facility:

NUMBER ON WAITING LIST* BY LEVEL & LOCATION

Level	Hosp.	Other Nsg Home	Home of Relative or Friend	Own Home/ Sr. Cit. Apt.	Boarding Home	Total
III	0	0	0	0	0	0**
II	0	0	0	0	0	0**
I	11	1	27	21	8	68
Total	11	1	27	21	8	68

* Waiting lists do not necessarily accurately reflect those in "need" of nursing home care.

** This Nursing Home will not admit persons who require level II or III care.

It is interesting to note that 24.5% of the current residents of Corner Brook Interfaith are from outside the local catchment area. Information provided regarding the ten most urgent cases on the waiting list for this facility indicated that a number of persons had applied for admission "in case their circumstances changed". These persons did not require nursing home care at the time of application but were applying for security reasons (i.e. in case their health deteriorated).

Western Memorial Special Care Unit

Western Memorial Special Care Unit provided the following information on applicants awaiting admission to that facility:

NUMBER ON WAITING LIST* BY LEVEL & LOCATION

Level	Hosp.	Other Nsg Home	Home of Relative or Friend	Own Home/ Sr. Cit. Apt.	Boarding Home	Total
III	20	0	2	0	0	22
II	0	0	0	0	0	0
I	0	0	0	0	0	0
Total	20	0	2	0	0	22

* Waiting lists do not necessarily accurately reflect those in "need" of nursing home care.

Western B - Stephenville - Channel

The 1981 census population of this area was as follows:

Health District	0 - 14	15 - 64	65 - 74	75 +	Total
Channel	3950	8050	530	265	12795
Stephenville	8035	15765	1035	560	25395
Total	11985	23815	1565	825	38190

Projections to 1991 and 2001 provided for the Royal Commission for Western Newfoundland were broken down into health districts by the consultants. The projected future populations for the Channel - Stephenville areas are as follows:

Year	Total Population	Population 65 +	% 65 +
1986	38095	2745	7.2
1991	38000	3100	8.2
2001	38000	3460	9.1

Application of the guidelines of 40 beds per thousand population 65 and over for level II and III care and 30 bed per thousand population 65 and over to the area population and projected population yields the following numbers:

Year	Population 65 +	Level II & III Beds @ 40/1000	Level I Beds @ 30/1000
1986	2745	110	82
1991	3100	124	93

Currently there are 63 beds in use for level II and III care at Bay St. George Senior Citizens Home and 16 beds for level III care in the chronic care unit in Channel for a total of 79 beds available. Although this currently means a deficit of 31 beds, when the 50 beds under construction in Stephenville Crossing will ensure a good supply of these beds in this area. It will not be until 2001 that this area would be in a deficit position for level II and III services and given that at least some of the beds now in use for level I care in Bay St. George Senior Citizens Home will probably be used in future for level II and III care, there is no need for additional beds of this sort in the area. Even if no long term care beds are developed in the Burgeo area, the addition of the population of this area to Western B would not produce a need for extra beds.

There are currently 15 beds in use for level I care at Bay St. George Senior Citizens Home. A total of seven beds are available in licensed Boarding Homes in this area, 3 in Cape Anguille and 4 in Piccadilly. Based on this, the area has a deficit of 60 beds for level I care. Level I beds for this area are required immediately.

Results of surveys completed by public health nurses and district social services offices yielded the following information:

ESTIMATED NUMBERS IN NEED OF THE
FOLLOWING SERVICES

District	Nursing Home		Boarding Home		Home Care	
	S. Serv	PHN	S. Serv.	PHN	S. Serv.	PHN
Channel	*	12	*	8	*	39
Cape St. George	*	2	*	4	*	5
Lourdes	*	0	*	0	*	8
Stephenville	3	6	3	4	6	6
Stephenville Crossing	6	3	6	3	4	13
Piccadilly	0	*	0	*	0	*
Total	9	23	9	19	10	71

* Indicates that no information was received because survey was not returned, office vacant, or no office in a particular community.

Bay St. George Senior Citizens Home provided the following information on applicants awaiting admission to that facility:

NUMBER ON WAITING LIST* BY LEVEL & LOCATION

Level	Hosp	Other Nsg Home	Home of Relative or Friend	Own Home/ Sr. Cit. Apt	Boarding Home	Total
III	16	0	10	3	0	29
II	6	2	5	4	0	17
I	1	0	8	9	1	19
Total	23	2	23	16	1	65

* Waiting lists do not necessarily accurately reflect those in "need" of nursing home care.

Discussion & Recommendations

Western A - Bonne Bay, Corner Brook, Burgeo

Home Care/Home Support Services

In the meetings held to discuss long term care in the Western A District, the consensus was that the priority should be to develop comprehensive continuous home care services. This was considered particularly important in several very isolated areas including the Burgeo - Ramea area from Grand Bruit to Francois and in the Jacksons Arm, Sops Arms areas where services of any sort are sporadic and very limited or non-existent. The use of non-professional staff with basic nursing skills such as are being trained and supervised by the V.O.N. in Corner Brook may well prove to be a reliable and cost effective alternative to professional staff who may be difficult to obtain in all areas. Such services must be supervised and assessed regularly by professionally trained individuals.

Bonne Bay

Home Care/Home Support

The development of comprehensive Home Care and Home Support services should be considered as a priority for Bonne Bay and surrounding areas. Because several of the communities are quite isolated, consideration should be given to training persons from each community to provide the necessary services under the supervision of a professional who could serve as Coordinator of Home Care services for several communities.

Bonne Bay Hospital had an occupancy rate of 58.8% in 1984/85. Approximately 50% of the patients in this hospital require long term care. Six beds have been designated for such care, however, hospital staff are concerned about the lack of appropriate space and programs for these patients. Because of the hospital's configuration (large wards), formal conversion to long term care is not appropriate. Since bed reductions would produce no benefit because of physical layout, no change in the short run is recommended.

When this cottage hospital is replaced, however, it is recommended that a facility be constructed to provide 2 to 4 beds for holding and observation purposes, 24 hour clinic facilities and beds for long term care. Based on the projected 1991 population of 65 + (592) this area could justify up to 24 beds for level II and III care (including 1 bed for respite).

Alternatively, consideration could be given to the development of enough level II and III beds to serve the area from Bonne Bay to just north of Port Saunders, especially since the consultants were advised that historically the people from Bonne Bay north have considered themselves a part of the Northern Region. A facility of 30 plus beds may be a more economically feasible undertaking.

Level I Services

It is also recommended that facilities appropriate for level I care be developed in this area. Based upon the projected 1991 population of 65 +, this area could support up to 18 level I beds, however, it is suggested that 12 beds be developed initially and pending acceptance of this concept of care, additional level I services be developed in the area in future.

Corner Brook

Home Care/Home Support

Home Care services in the Corner Brook area have been provided for over ten years by Western Memorial Hospital through purchased services from the V.O.N. This is generally considered to be a good service however the consultants were advised that there was a need for expansion. In view of the pressure on beds at Western Memorial Hospital and the shortage of long term care facilities in the Western A district, this expansion should be accomplished as soon as possible.

Western Memorial Hospital

Although the total short term occupancy rate of this hospital during 1984/85 was 75.8%, occupancy on the medical and pediatric services was extremely high (111.4% and 96.1% respectively). Surgical occupancy was reported to be 63.4%, however the consultants have been informed that since the addition of an orthopedic surgeon to the hospital's medical staff, surgical occupancy has increased significantly. It can be anticipated that provision of orthopedic services may increase the pediatric surgical volume thus pushing pediatric occupancy even higher.

Obstetrical patient days would appear to be somewhat higher than might be expected since reported days were 60.6% higher than newborn patient days (obstetrical beds 29, bassinets 30). Since Western Memorial serves as a referral centre for obstetrics, it is reasonable to assume that obstetrical patient days would be higher than those experienced in hospitals where primarily uncomplicated pregnancies are managed (i.e. obstetrical patient days at these hospitals would be approximately 20% higher than newborn patient days). However, because reported patient days are so much higher than this at Western Memorial, it suggests that at least some portion of these days would be antenatal admissions, not all of which would be medically indicated. It may therefore be possible to achieve reductions in obstetrical occupancy, perhaps thereby freeing up beds for other uses. It is suggested that this could be accomplished through increased use of hostel facilities. This will become increasingly important as the medical staff at Burgeo Hospital have indicated their intention to refer all obstetrics to Corner Brook in future.

In regards to medical occupancy, it is recommended that the hospital improve facilities for and coordination of preadmission diagnostic testing and that the use of hostel facilities be increased for patients not requiring admission. It is also anticipated that an increase in the inventory of beds for Level II and III care in this region should relieve pressure on medical beds in the future.

The consultants were informed that increased use of day surgery facilities at Western Memorial could lead to decreased surgical patient days and in view of the fact that surgical days have been increasing due to development of orthopedic surgery, this is strongly advised.

The designated pediatric unit for the Western Region should be established at Western Memorial. Based on the discussion paper on pediatrics and the recommended guideline of 1.125 pediatric beds per thousand population aged 0 - 14, the Western Region requires 30 beds in 1986, decreasing to 27 in 1991 and 23 in 2001.

The pediatric unit at Western Memorial Hospital is reported to have 25 beds, however, the occupancy rate of these beds in 1984/85 was reported to be 96.1%. A review of reported pediatric patient days at this hospital indicated an increase in these days over the past two years. This reflects a change in the hospital's policy regarding the age of children admitted to the pediatric unit. In response to pressure on adult beds, the upper age limit was increased from 12 years to 16 years of age. The consultants were also advised that on occasion, adults may be admitted to these beds and these days may be reported as pediatric days. In view of this, and as action is taken to relieve pressure on medical and surgical days, it is likely that pediatric days reported will decrease. In the short term, it is recommended that the number of beds in the Pediatric unit be increased to 30, however in view of the anticipated changes discussed above, it may be possible to decrease the size of the unit in the future.

There are currently 30 patients in the Long Term Care Unit on the fifth floor of this hospital, 15 of whom are elderly patients with psychiatric problems. This unit was designed specifically for rehabilitation, not for the purpose to which it is currently being put. In the long term, when other facilities are available, it is recommended that these patients be relocated to more appropriate locations.

Western Memorial operates an 8 bed rehabilitation service in its Special Care Unit. It is recommended that a regional general rehabilitation service be established at Western Memorial Hospital and that the number of beds be expanded from 8 to 24. This number is based upon the projected 1991 total population of the Western Region as well as the same population for the Central A district of Baie Verte and Springdale since patients from this area are currently referred to Corner Brook for rehabilitation services. If the development of rehabilitation services in St. Anthony is not considered feasible because of difficulties in recruiting enough staff (i.e. physiotherapists, occupational therapists, etc.), it is recommended that the number of beds for rehabilitation at Western Memorial be expanded to 30.

Rehabilitation services in Corner Brook could not only meet the needs for slow paced geriatric rehabilitation, but could also augment the services provided to patients requiring special rehabilitation services normally provided in St. John's. Since beds for such services are so limited in St. John's, if services were available in Corner Brook, patients could be discharged earlier thus relieving pressure on beds in St. John's.

The expansion of rehabilitation services in Corner Brook should be considered as the top priority for development of such services in the province. No renovations would be required at Western Memorial since there is a 30 bed unit specifically designed for rehabilitation on the 6th floor which is currently empty. Extra staff, in particular, Physiotherapists, Occupational Therapists, Recreational Therapists would however, be required. The only changes required would be that use of beds on the 6th floor for hostel purposes would have to be discontinued and hostel facilities developed elsewhere. There is a perception that hostel facilities should be expanded in this area anyway, particularly if Burgeo is to discontinue its obstetrical services and refer all patients to Corner Brook and, if reductions in medical patient days are to be effected.

Finally, it is recommended that the 8 beds currently used for Rehabilitation in the Special Care Unit revert to long term care use and that all patients requiring intensive rehabilitation be admitted to the rehabilitation unit at the hospital.

In summary, in the short term no change to the total number of beds at this hospital is recommended. The increase in Pediatric beds should be accomplished within the present compliment of beds. Every effort to decrease medical and obstetrical patient days should be made with a view to decreasing the number of these beds in future. Also, when additional level II and III beds are available in this region, it may be possible to close the 30 bed long term care unit.

Western Memorial Special Care Unit should continue to be regarded as a priority for renovation by Western Memorial. A considerable amount has been done to make the building as pleasant as possible, however problems remain, including a lack of wheelchair accessible bathroom facilities and lack of storage space and lounge areas. There is also a shortage of occupational, physio and recreational therapists since the current staff (1 Physiotherapist, 1 Physiotherapist Aide, 1/2 Occupational Therapist and 1 Occupational Therapist Aide) not only serve the needs of all residents (including 8 rehabilitation patients) but also the needs of the 35 day hospital patients.

Corner Brook Interfaith Home does not admit persons requiring level II and III care, nor do they admit persons who are mentally or physically handicapped or mentally ill. Concerns have been expressed regarding overcrowding. All of these factors limit the ability to provide level II and III care for citizens of this area and have resulted in inappropriate placement of patients in other institutions (i.e. beds in Western Memorial Hospital).

Although this facility was not designed to provide level II and III care, it is in fact being provided. A study was done some time ago to determine the feasibility of converting the residential area to a nursing care area. Results of this study were not available to the consultants. It is recommended that if structurally feasible, the Home be renovated to provide a total of 93 beds* for level II and III care and 4 - 5 beds for respite care, emergency admissions from the community and convalescent care. Appropriate numbers and types of staff must be provided and programs developed. If conversion is deemed feasible, planning to accomplish this should begin within the next couple of years as there are many placement problems due to the shortage of level II and III beds in this area.

If conversion is not cost effective, a new facility to provide 40 - 45 beds for level II and III care should be built. Opportunities for sharing of services should be pursued aggessively.

* It is possible that the total number of beds should be less than 97-98 to permit provision of adequate space for occupational and physiotherapy activities and community outreach programs.

Level I Facilities

Additional facilities for Level I care are needed. The numbers of beds required in the immediate Corner Brook area will be dependent upon how many beds are developed in other areas of the region (i.e. Burgeo, Bonne Bay) and on any changes which may be made in the future regarding the role of Corner Brook Interfaith. As mentioned previously, based upon the estimated 1986 population of this area, there is a total deficit of 32 level I beds in Western A. However, it should be noted that in the Corner Brook area alone, there are unlicensed Boarding Houses with a capacity of 30 residents to which the hospital routinely refers people because there are no other alternatives (i.e. licensed facilities). In the short term, it is recommended that 12 beds for level I care be developed in the Corner Brook area.

Burgeo/Ramea

Since there are currently no facilities or services to meet the needs for long term care of the population of Burgeo and the outlying isolated coastal communities, there is considerable pressure to develop some. Burgeo Hospital is no longer appropriate for acute care and is in need of improved facilities for ambulatory care. It could not be easily renovated to provide appropriate facilities for long term care; therefore in time a new facility to address all of these needs will be required. The consultants recommend however, that this area be developed as a test site for provision of comprehensive home care services. It is recommended that the Hospital coordinate the provision of these services but that persons living in Burgeo and each of the coastal communities to the west and east from Francois to Grand Bruit, be trained and employed to provide Home Care and Home Support services in their respective communities. Adequate funding to ensure that comprehensive, reliable services are provided is critical to the success of this pilot project. If this is not done, health care professionals and those who could benefit from such services will not take advantage of them, but will continue to view more costly institutional services as the only viable alternative.

It is also recommended that planning begin soon for the construction of a new facility in Burgeo which would provide six beds for acute care (holding/observation), ambulatory clinic facilities and two beds formally designated for respite and convalescent care and emergency admissions from the community. Such facilities should be adequate to meet the needs for acute care since the 15 beds currently in operation are used less than half the time. Surgery is presently limited almost completely to what can be done using a local anesthetic and plans are that in future, only emergency deliveries will be performed at this hospital.

Although provision of long term care beds is not recommended at the time of construction, the facility should be designed to permit expansion to provide appropriate facilities for level II and III care. Based on the projected 1991 population 65 years and over of these communities (402), up to 16 beds for level II - III care might be justified. However, a complete evaluation of the impact of home care services on the need for institutional beds for long term care should be carried out first to determine if that number of beds is actually required. This evaluation should be carried out 2 - 3 years following the establishment of comprehensive home care to all communities.

Home care and home support services could also have an impact on the need to develop beds for level I care in this area. The projected 1991 population 65 years and over could support 12 beds However, as with level II - III beds, the need should be evaluated after home care services have been provided for a couple of years.

In the short term, a number of recommendations are made as follows:

1. Formal designation of 2 beds in Burgeo Hospital for respite care.

2. Training of a hospital staff member as a Physio Aide to assist in rehabilitation of stroke patients and others who require such therapy. This person could also be involved in the provision of home care in the area.

3. Development of a meals on wheels program with particular emphasis on diabetics in the area who are known to have problems with control of diet. This program could be developed by the hospital.

4. Renovation of the Emergency Treatment area of the hospital in Burgeo to provide an observation room and an emergency room separate from the regular treatment room.

Western B - Stephenville - Channel

Home Care/Home Support

In the meeting held to discuss requirements for long term care services in this area, the consensus was that the greatest need was for services to be provided in the community.

The Hospital in Stephenville and the Senior Citizens Home are currently involved in a study to assess needs for long term care with an emphasis on Home Care and it is hoped that a Home Care program will be developed.

The consultants strongly recommend that the development of comprehensive home care and home support services for acute and long term care be undertaken as a priority, especially in view of the extremely limited services available for level I care in this district.

The consultants were advised that there are several persons in this area who have received training in home nursing skills through the Hospital. These persons have previous experience in the provision of Home Care, and their services were very well received in the past. Supervision and coordination of Home Care/Home Support services could be provided through the Senior Citizens Home or Hospital.

Sir Thomas Roddick Hospital reported 89 beds and an occupancy rate of 67.4% during 1984/85. Medical occupancy, at 87.7% is high reflecting the full time presence of 16 long term care patients in the hospital. Assuming that these patients will be accommodated at Bay St. George Senior Citizen Home when the 50 bed expansion is completed, a reduction of 5840 patients days (16 beds at 365 days) should be possible and it is recommended that these beds be closed.

Although surgical occupancy at 83.5% is also high, plans to improve day surgery, combined with improved preadmission diagnostic testing should decrease surgical admissions and patient days.

Obstetrical occupancy has declined over the past two years however, because of the discrepancy between obstetrical and newborn patient day statistics, it appears that obstetrical beds may be used for medical and surgical overflow. With anticipated reductions in both medical and surgical patient days, this should not be necessary in future and therefore over time, a reduction in obstetrical beds should be possible.

In line with the recommended direction for pediatric services, this hospital cannot justify a pediatric unit. Occupancy of the 22 pediatric beds in 1984/85 was only 29%. The consultants were advised however, that there will continue to be a requirement for a number of pediatric beds to accommodate "social" admissions, especially for infants. Therefore five beds are recommended for a crib room in one of the adult units. Children requiring admission and care by a Pediatrician should be referred to Corner Brook.

In summary, it is recommended that the capacity of this hospital be reduced to 56 beds through increased use of day surgery, closure of beds now used for long term care when beds are available at Bay St. George Senior Citizens Home and a reduction in pediatric beds. This should permit more flexibility in the use of space at the hospital and may permit further development of outreach services.

Bay St. George Senior Citizens Home should have 2 - 3 beds designated for respite care, short term emergency admissions and convalescent care. In view of the fact that there will be a surplus of level II - III beds in this district if all 50 beds in the addition under construction at Bay St. George Senior Citizens Home are opened, it is recommended that only 35 beds be opened and that funds which would have been budgeted for the operation of the other 15 beds be allocated for the provision of Home Care services in Stephenville, Stephenville Crossing, Port aux Port Peninsula, and surrounding areas. (Home Care services are already provided in the Channel/Port aux Basque area).

The feasibility of developing day hospital services for the elderly in the Stephenville - Stephenville Crossing - Port aux Port Peninsula area should be studied further. If found to be feasible, staff such as Occupational, Physio and Recreational Therapists which are required to enrich services now available at the Nursing Home could play a role in this program as well as in Home Care.

Level I Facilities

Twelve level I beds in the Stephenville, Stephenville Crossing and Port aux Port Peninsula areas should be developed either through licensing of personal care homes or construction of congregate living facilities in close association with the nursing home. As these services become well accepted, the total number of beds should be increased to 30 - 35.

Channel

Charles L. LeGrow Health Centre reported 40 beds and an occupancy of 58.4% in 1984/85. However there are currently only 20 acute care beds in operation. There is also an 18 bed long term care unit in this facility, two beds of which are used for respite care. No change to this present inventory of beds (including five pediatric beds) is recommended.

Funding for the provision of Day Hospital services (including funding for the service of the van) should be permanent rather than dependent upon that provided through the Social Services "20 week program".

Level I Facilities

The development of 12 beds for level I care through development of personal care homes or congregate living facilities in close association with the hospital is recommended as a high priority. Once these services become well accepted, the number of level I beds should be increased to between 20 and 25.

Other Services

Joint Assessment Committee

Initial efforts between Channel, Stephenville and Corner Brook to establish a formal Joint Assessment Committee for Long Term Care are a very positive move and should be actively pursued especially in view of the many placement problems experienced in this region. Such efforts should help substantially to improve placement of patients in the region in the short term until additional facilities can be developed.

Western Region

SUMMARY OF PRESENT CAPACITY* AND RECOMMENDED CAPACITY

District/Facility	Total Capacity (1985/86)	Recommended Capacity				
		Acute (2001)	Rehab (1991)	Level II & III (1991)	Level I (1991)	Respite** (1991)
Western A						
Bonne Bay	21	2-4		29		1
Western Memorial Hospital	297	267	24-30***	30****		
Western Memorial Spec. Care Unit	60			60		
Corner Brook Interfaith	102			93		4-5
Burgeo Hospital	15	6		16*****		2
Personal Care	51				75	
Subtotal		275-277	24-30	228****	75	7-8
Western B						
Sir Thomas Roddick Hospital	89	56				
Bay St. George Sr. Citizens Home	78			95-96	15	2-3
Charles LeGrow Health Centre	38	20		16		2
Personal Care	7				31	
Subtotal		76		111-112	46	4-5
Total Recom'd Capacity		351-353	24-30	340-341****	121	10-12
Present Total Capacity		(412)	(8)	(182)	(124)	(2)

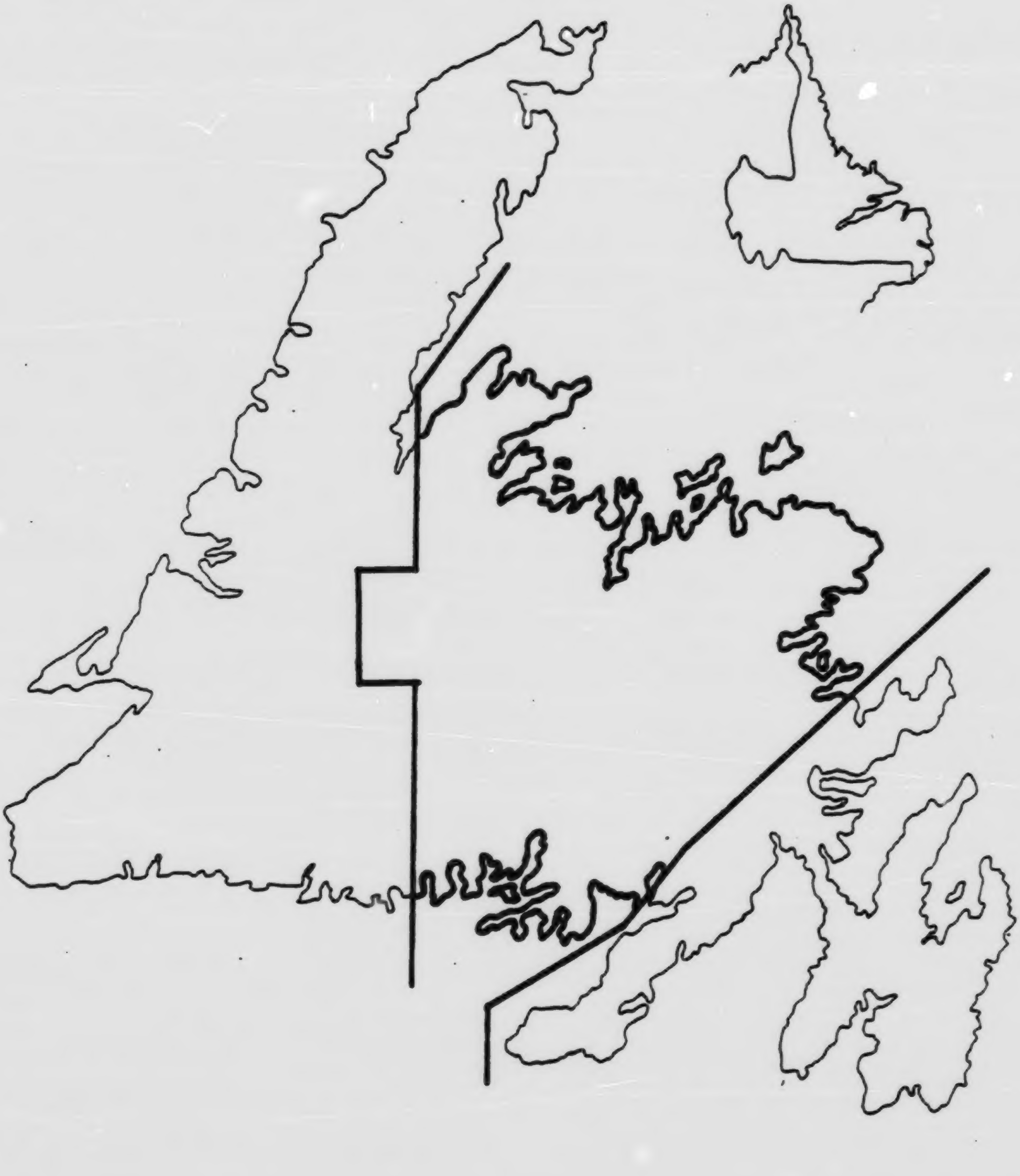
* Present capacity based upon beds open at time of Consultants visit or on information received since visit.

** Includes convalescent and emergency use.

*** Note that no construction or renovation should be required to provide the 24 - 30 beds for Rehabilitation at Western Memorial Hospital since there is a 30 bed purpose designed Rehabilitation unit currently vacant.

**** The 30 beds for level II and III care at Western Memorial are recommended only until other such facilities are available at which time these beds should be closed.

***** The 16 beds recommended for Burgeo are based upon application of the norm of 40 beds/1000 population 65+. However, if provision of Home Care/Home Support services is effective it is anticipated that fewer than 16 beds may be required. This should be evaluated before providing beds for level II-III in this area. The need for level I beds should be evaluated at the same time.



Central Newfoundland

General Description

This area includes all of the central part of the island of Newfoundland from the area west of Hampden to Terra Nova National Park in the east. The region has been divided into five health districts for planning purposes as follows:

Central A - Baie Verte - Springdale
Central B - Grand Falls, Buchans, Botwood
Central C - Harbour Breton - St. Albans
Central D - Lewisporte - Twillingate
Central E - Gander, Fogo, Brookfield

This area contains the relatively urbanized towns of Gander and Grand Falls as well as a number of isolated areas including Fogo and Harbour Breton.

Health Problems

The main problems reported in this area were similar to Newfoundland as a whole. There are in addition, however, small pockets of genetic disorders such as haemophilia.

Inventory of Health Care Services

This region includes two regional hospitals providing specialty services - Central Newfoundland Hospital in Grand Falls and James Paton Memorial Hospital, Gander. There are seven hospitals in the region providing community level acute care services, five nursing homes and five boarding homes. Following is a summary of these facilities by community and district.

Central A - Baie Verte - Springdale

Baie Verte

The M.J. Boylen Hospital in Baie Verte is a 39 bed acute care facility providing primary inpatient and outpatient care. It has formally designated 8 beds for long term care so that there are, in fact, 31 acute care beds in operation. Eight of the 31 are assigned to pediatrics and 4 to obstetrics.

There are no nursing home beds or licensed boarding home beds in this area.

Springdale - Green Bay

The Springdale Hospital is a 25 bed acute care community level hospital located in Springdale. It currently operates at a capacity of 22 beds and provides a range of community level acute care services including medicine, surgery, pediatrics and obstetrics.

Long term care services provided by the Green Bay Health Care Centre (which also administers the Springdale Hospital) include the following:

Valley Vista Senior Citizens Complex provides 80 beds (including 2 respite beds) for nursing care; a 24 bed residential unit; and 68 senior citizens cottages. There is a Home Care Program staffed by 2 registered nurses and 4 homemakers which covers a radius of 40 miles from the hospital.

A developmental maximization unit for 6 disabled children is located in the hospital and there is a group home for 6 disabled children on the hospital site.

Central B - Grand Falls, Buchans, Botwood

Grand Falls

The Central Newfoundland Regional Health Centre in Grand Falls is the regional hospital for the western portion of Central Newfoundland and for certain specialties (i.e. psychiatry, urology, ENT, G.I., and Peripheral Vascular Surgery) for all of Central Newfoundland. Its 1984/85 bed distribution was reported as follows: 42 medical beds, 78 surgical beds, 13 ICU beds, 20 obstetrical beds, 14 psychiatric beds, and 30 pediatric beds. Although there are no designated long term care beds, there are on average 12 - 20 patients in the hospital who require placement in a long term care facility.

The hospital has been providing a Home Care program in the area since 1967/68. The primary emphasis of the program has been on follow up of patients discharged from hospital following surgery, etc. Only about 20% of patients seen, are for long term care.

Carmelite Interfaith Home is a 102 bed facility for long term care. It has been providing Day Care services for about 4 - 5 persons by employing persons through the Social Services 20 week program. This has not been a totally satisfactory arrangement. The Home has expressed an interest in developing a full fledged meal program and a well coordinated Home Care service for the elderly in the area, particularly for those on the waiting list for Carmelite House. In addition, the Home has indicated that there is a need for formalized respite beds to serve the area and would be interested in providing this service.

There is a 20 bed licensed boarding home in Bishops Falls.

Buchans

The A.M. Guy Hospital recently converted from acute care to long term/chronic care and now has 18 beds for level II and III care, one holding bed and one bed for palliative care. The consultants have been advised that these beds are not being well utilized however, primarily because of a reluctance to place people in a facility so far away from their homes (i.e. persons from Grand Falls and surrounding areas).

Botwood

Botwood Hospital reported 46 beds and a total occupancy of 58.5% in 1984/85. This hospital is due to close when a new 75 bed long term care facility planned for this area opens. Home Care is provided in this area by the Public Health Nurse.

Central C - Harbour Breton - St. Albans

Harbour Breton

The only health care facility in this district providing inpatient care is the Harbour Breton Hospital. This hospital, operated under the auspices of the Central Newfoundland Regional Health Centre Board, reported 19 beds broken down as follows: 11 surgical and undistributed beds, 5 obstetrical beds, and 3 pediatric beds. Respite services are provided on an informal basis at the hospital. A pilot project for Home Care was initiated recently by the hospital utilizing a half time nurse and homemakers employed through the 20 week Social Services program.

Central D - Lewisporte - Twillingate

Twillingate

The Notre Dame Bay Memorial Hospital has a capacity of 69 beds of which 54 are acute care and 15 are level III, long term care. It does not provide day care services or respite but does provide meals on wheels to the local catchment area and plans to start a home care program in the immediate future.

Lewisporte

North Haven Manor is a 76 bed nursing home which provides level I, II and III care and operates 100 senior citizens cottages. Two beds are designated for respite care. The home provides meals on wheels and day care services, with limited home care being provided through the local public health nursing office.

There is a 44 bed licensed boarding home in Porterville.

Central E - Gander, Fogo, Brookfield

Gander

James Paton Memorial Hospital is a 164 bed acute care institution (currently operating 157 beds). It serves as the regional hospital for the eastern half of Central Newfoundland and for certain designated specialties (e.g. orthopedics) as the referral centre for all of Central Newfoundland. The hospital is administered by the Gander and District Hospital Board which also has responsibility for the hospitals in Fogo and Brookfield. It does not provide any specific long term care programs at present.

Lakeside Home is a 123 bed nursing home which opened in 1972 and expanded in 1985. The new wing contains a 25 bed unit designed for old age psychiatry. It currently accommodates 88 level II and III residents and 35 level I residents. It operates a home care program, a day care program and meals on wheels. One bed is designated for respite care.

Fogo

Fogo Hospital is an 18 bed acute care cottage type hospital built in 1952 which is in a reasonably good state of repair for its age and type of construction. The hospital does not formally provide any long term care services. There are, however, some long term care patients in the hospital all the time. In addition, the hospital provides informal respite services on occasion.

Brookfield - Valleyfield

Brookfield Hospital is a 30 bed acute care facility operated by the Gander and District Hospital Board. The original hospital was built in 1944, with expansions and renovations being undertaken in the 1960's and 1970's. It has major space problems in outpatient facilities and the inpatient unit is less than optimal for either acute or long term care. Approximately 75 deliveries occur each year. Home care services are provided by the hospital.

Bonnews Lodge is a 45 bed nursing home located approximately one mile away from the Brookfield Hospital. The facility opened in its current location approximately four years ago. It accommodates 20 level III, 15 level II and 10 level I residents. A day care program for approximately 18 local residents is provided. No respite beds are available at present, although there are requests for this service.

There are two 20 bed licensed boarding homes in this district. One is located in Ladle Cove and one in Musgrave Harbour. There is a four bed group home for the mentally retarded located in Gander.

Population

Statistics from the 1981 census provided the following information on the population of the Central Newfoundland region:

Health District	0 - 14	15 - 64	65 - 74	75 +	Total
Central A Baie Verte-Springdale	7000	12565	865	460	20890
Central B Grand Falls, etc.	9620	20555	1570	755	32500
Central C Harbour Breton	3720	6380	505	275	10880
Central D Lewisporte, etc.	6515	12375	1280	665	20835
Central E Gander, etc.	11565	24210	1981	1176	38932
Total	38420	76085	6201	3331	124037

The projected future populations for Central Region are as follows:

Year	Total Pop.	0 - 14	% 0 - 14	65 +	% 65 +
1986	125296	34681	27.7	11047	8.8
1991	126547	31131	24.6	12594	10.0
2001	129898	26329	20.3	14486	11.2

Assessment of Needs

The guidelines of 3.5 - 4.0 beds per thousand population were considered by the consultants to be a useful starting point in determining beds required for acute care. A review of current and anticipated future practices however, indicated that approximately 10% of the services required are of a tertiary nature such as can only be obtained in St. John's. Therefore, the actual guidelines which have been used are 3.15 to 3.60 acute care beds per thousand population (i.e. 10% of beds from each region assigned to St. John's). Pediatric bed (i.e. designated pediatric units) requirements have been determined by applying the norm of 1.125 beds per thousand to the regional populations and have been considered as part of the total inventory of acute care beds.

Application of the guidelines to the population of Central Region yields the following numbers:

Year	Total Pop.	Acute Care Beds @ 3.15-3.60	Pop. 0-14	Ped. Beds @ 1.125/1000	Acute Beds Req'd (excl. Peds)
1986	125296	395-451	34681	39	356-412
1991	126547	399-456	31131	35	364-421
2001	129898	409-468	26329	30	379-438

Currently there are 546 acute care beds (including pediatric beds) available in the hospitals in Central Region. This figure is based on the beds staffed and in operation reported to the consultants at the time of our visits to the hospitals, not on beds reported on the Annual Returns to the Department of Health.

Therefore there is a surplus to the norm of 95 - 151 acute care beds in 1986.

Rehabilitation

As indicated in section 10.2 of this report, there is a shortage of rehabilitation beds and services throughout Newfoundland and Labrador. There are no rehabilitation beds located in Central Newfoundland and access to beds at the Miller Centre in St. John's is very limited.

Application of the recommended guideline of .2 beds per thousand population to the total projected population of Central Newfoundland yields a requirement for 25 beds in 1986 and 26 in 2001. As discussed in the section on Western region, Central A district may continue to refer to Corner Brook for rehabilitation. If the population of Central A is deducted from Central region, the number of beds required for 1986 would be 21. While ambulatory care services may provide an acceptable level of service with lower bed numbers, it is clear that this service should be developed in the region at the earliest opportunity.

Long Term Care

Central A - Baie Verte - Springdale

The 1981 census population of this area was as follows:

Health District	0 - 14	15 - 64	65 - 74	75 +	Total
Baie Verte	3345	6065	350	190	9950
Springdale	3655	6500	515	270	10940
Total	7000	12565	865	460	20890

Projections to 1991 and 2001 provided for the Royal Commission for Central Newfoundland were broken down into health districts by the consultants. The projected future populations for the Baie Verte - Springdale area are as follows:

Year	Total Population	Population 65 +	% 65 +
1986	20945	1522	7.3
1991	21000	1720	8.2
2001	21200	2105	9.9

In 1981 the population of this district was slightly younger than Central Region as a whole (6.3% compared to 7.7% aged 65 + in the region). By 2001, the elderly population is expected to comprise 9.9% of the total compared to 11.2% for central region and 10.9% for the province as a whole.

There is a perception among health care providers in the area that their population is relatively older than the province as a whole and that the Baie Verte peninsula has a relatively older population than the Springdale - Green Bay area. This perception does not correspond with census statistics.

Application of the guidelines of 40 beds per thousand population 65 + for level II and III care and 30 beds per 1000 level I care to the area population and projections yield the following numbers:

Year	Population 65 +	Level II & III Beds @ 40/1000	Level I Beds @ 30/1000
1986	1522	61	46
1991	1720	69	52

Currently there are 67 beds in use at Valley Vista for level II and III residents and 8 beds at M.J. Boylen Hospital for a total of 75 beds available. Thus there is currently a surplus to the norm of 14 beds. There are 36 beds in use for level I care at Valley Vista for a current statistical deficit of 10 level I beds. According to the norms, additional level II and III beds would not be required until the mid 1990's, while more level I beds are required now.

Results of surveys completed by public health nurses and district social services offices yielded the following results:

ESTIMATED NUMBERS IN NEED OF THE
FOLLOWING SERVICES

District	Nursing Home		Boarding Home		Home Care	
	S. Serv.	PHN	S. Serv.	PHN	S. Serv.	PHN
Springdale	6	3	7	0	5	41
Baie Verte	12	72	9	38	7	276
Robert's Arm	*	*	*	*	*	*
Total	18	75	16	38	12	317

* Indicates that no information was received because survey was not returned, office is vacant, or no office in a particular community.

There is obviously a large discrepancy in the needs as perceived by public health nurses and social services offices. The numbers provided by Baie Verte public health nurses suggest a total of 430 people in need of care - or 268 over age 60. Although our population statistics are for the age of 65 and over, this suggests that over 40% of the elderly population of the Baie Verte peninsula would require either institutional placement or comprehensive home care. This figure is substantially higher than all other areas of the province and than all national and international averages. Such data reinforces the comments in the introduction to this report of the subjective nature of the assessments done for the surveys.

Valley Vista provided the following information on applicants awaiting admission to that facility:

NUMBER ON WAITING LIST* BY LEVEL & LOCATION

Level	Hosp	Other Nsg Home	Home of Relative or Friend	Own Home/Sr Cit. Apt.	Board. Home	Total
III	4	1	3	4	0	12
II	7	0	21	3	1	32
I	6	0	22	4	0	32
Total	17	1	46	11	1	66

* Waiting lists do not necessarily accurately reflect those in "need" of nursing home care.

Central B - Grand Falls, Buchans, Botwood

The 1981 census population of this area was as follows:

Health District	0 - 14	15 - 64	65 - 74	75 +	Total
Botwood	2630	5000	425	180	8235
Buchans	585	1460	90	20	2155
Grand Falls	6405	14095	1055	555	22110
Total	9620	20555	1570	755	32500

Projections to 1991 and 2001 provided for the Royal Commission for Central Newfoundland were broken down into health districts by the consultants. The projected future populations for the Botwood, Buchans and Grand Falls areas are as follows:

Year	Total Population	Population 65 +	% 65 +
1986	32350	2732	8.4
1991	32200	3140	9.7
2001	32000	3607	11.3

In 1981, the percentage of the population of this area aged 65 and over was 7.1%, only very slightly lower than the provincial average of 7.7%. By 2001, it is projected that this trend will reverse with the area's elderly comprising 11.3% of the total population, just slightly higher than the projected provincial average of 10.9%. This factor has been considered in the consultants' recommendations.

Application of the guidelines of 40 beds per thousand population 65 and over for level II and III care and 30 beds per thousand population 65 and over for level I care to the area population and projected population would yield the following numbers:

Year	Population 65 +	Level II & III Beds @ 40/1000	Level I Beds @ 30/1000
1986	2732	109	82
1991	3140	126	93

Currently there are 83 beds in use at Carmelite House for Level II and III residents and 18 beds at A.M. Guy Hospital for the same levels of care for a total of 101 beds available. Thus there is currently a deficit of 8 beds. There are currently 19 beds in use at Carmelite House for level I care and a total of 20 beds in licensed boarding homes appropriate for level I care for a total of 39. Thus, according to the norm, there is a current deficit of 43 level I beds.

With the 75 beds planned for the new facility in Botwood, there will be no requirement for additional beds for long term care in this district.

Results of surveys completed by public health nurses and district social services offices yielded the following results:

ESTIMATED NUMBERS IN NEED OF THE FOLLOWING SERVICES

District	Nursing Home		Boarding Home		Home Care	
	S. Serv.	PHN	S. Serv.	PHN	S. Serv.	PHN
Grand Falls	*	*	*	*	*	*
Botwood	0	31	0	0	15	10
Buchans	*	*	*	*	*	*

* Indicates that no information was received because survey was not returned, office is vacant, or no office in a particular community.

Carmelite House provided the following information on applicants awaiting admission to that facility:

NUMBER ON WAITING LIST* BY LEVEL & LOCATION

Level	Hosp	Other Nsg Home	Home of Relative or Friend	Own Home/Sr Cit. Apt.	Board. Home	Total
III	10	8	13	2	2	35
II	4	1	18	5	2	30
I	2	1	5	16	6	30
Total	16	10	36	23	10	95

* Waiting lists do not necessarily accurately reflect those in "need" of nursing home care.

Central C - Harbour Breton - St. Albans

The 1981 census population of this area was as follows:

Health District	0 - 14	15 - 64	65 - 74	75 +	Total
Harbour Breton	2310	3855	350	200	6715
St. Albans	1410	2525	155	75	4165
Total	3720	6380	505	275	10880

Projections to 1991 and 2001 provided for the Royal Commission for Central Newfoundland were broken down into health districts by the consultants. The projected future populations for the Harbour Breton - St. Albans area are as follows:

Year	Total Population	Population 65 +	% 65 +
1986	10940	840	7.7
1991	11000	900	8.2
2001	11200	1026	9.2

In 1981, the percentage of the total population that was 65 years and over was 7.2%, slightly lower than the provincial average of 7.7%. By 2001, it is projected that those 65 and over will comprise 9.2% of the population of this area, somewhat lower than the projected provincial average of 10.9%. This factor has been considered in the consultants' recommendations.

Application of the guidelines of 40 beds per thousand population 65 and over for level II and III care and 30 beds per thousand level I care to the area population and projections would yield the following numbers:

Year	Population 65 +	Level II & III Beds @ 40/1000	Level I Beds @ 30/1000
1986	840	34	25
1991	900	36	27

There are no beds available in this area for Level II and III and/or Level I care.

Newfoundland Bed Study - 8514

Results of surveys completed by public health nurses and district social services offices yielded the following results:

ESTIMATED NUMBERS IN NEED OF THE FOLLOWING SERVICES

District	Nursing Home		Boarding Home		Home Care	
	S. Serv.	PHN	S. Serv.	PHN	S. Serv.	PHN
Milltown	2	0	10	0	5	5
Bay d'Espoir	*	2	*	10	*	5
Harbour Breton	2	5	10	5	3	12
Total	4	7	20	15	8	22

* Indicates that no information was received because survey was not returned, office is vacant, or no office in a particular community.

Central D - Lewisporte - Twillingate

Population

The 1981 census population of this area was as follows:

Health District	0 - 14	15 - 64	65 - 74	75 +	Total
Lewisporte	2990	5550	575	320	9435
Twillingate	3525	6825	705	345	11400
Total	6515	12375	1280	665	20835

Projections to 1991 and 2001 provided for the Royal Commission for Central Newfoundland were broken down into health districts by the consultants. The projected future populations for the Lewisporte - Twillingate area are as follows:

Year	Total Population	Population 65 +	% 65 +
1986	21415	2242	10.5
1991	22000	2540	11.5
2001	23000	2921	12.7

In 1981, the population of this district was slightly older than the provincial average (9.3% compared to the provincial average of 7.7%) and is projected to remain older by 2001 (12.7% compared to 10.9%). This factor has been taken into account in recommending bed numbers.

Application of the guidelines of 40 beds per thousand population 65 and over for level II and III care and 30 beds per thousand for level I care to the population projections yields the following numbers:

Year	Population 65 +	Level II & III Beds @ 40/1000	Level I Beds @ 30/1000
1986	2242	90	67
1991	2540	102	76

Currently there are 82 level II and III beds in use in the area, leaving a deficit of 8 beds. There are 48 level I beds in use, for a deficit of 19 beds.

Results of surveys completed by public health nurses and district social services offices yielded the following numbers:

ESTIMATED NUMBER IN NEED OF THE FOLLOWING SERVICES

District	Nursing Home		Boarding Home		Home Care	
	S. Serv.	PHN	S. Serv.	PHN	S. Serv.	PHN
Twillingate	4	30	5	10-15	10	100
Lewisporte	-	*	-	*	-	*
Summerford	*	*	*	*	*	*
Comfort Cove	*	*	*	*	*	*
Total	4	30	5	10-15	10	100

* Indicates that no information was received because survey was not returned, office is vacant, or no office in a particular community.

The Lewisporte Social Services office provided comments, but no numbers.

North Haven Manor provided the following information on applicants awaiting admission to that facility:

NUMBER ON WAITING LIST* BY LEVEL & LOCATION

Level	Hosp.	Other Nursing Home	Home of Relative or Friend	Own Home/ Sr Cit. Apt	Boarding Home	Total
III	47	7	65	0	2	121
II	4	1	54	4	1	64
I	0	0	12	15	3	30
Total	51	8	131	19	6	215

* Waiting lists do not necessarily accurately reflect those in "need" of nursing home care.

In the meeting held to discuss long term care in this area, there was general agreement that top priority should be given to the development of comprehensive home care services.

Central B - Gander, Fogo, Brookfield

Population

The 1981 census population of this area was as follows:

Health District	0 - 14	15 - 64	65 - 74	75 +	Total
Fogo	1260	2400	245	120	4025
Brookfield	1755	3783	382	230	6150
Gander	8550	18027	1354	826	28757
Total	11565	24210	1981	1176	38932

Projections to 1991 and 2001 provided for the Royal Commission for Central Newfoundland were broken down into health districts by the consultants. The projected future populations for the Gander, Fogo, Brookfield area are as follows:

Year	Total Population	Population 65 +	% 65 +
1986	39640	3729	9.4
1991	40347	4294	10.6
2001	42498	4827	11.4

In 1981 the percentage of elderly in this area was close to the provincial average of 7.7%. By 2001, the percentage of elderly in this district is predicted to be slightly greater than the projected provincial average of 10.9%. This factor has been considered in assessing the need for beds in this area.

Assessment of Needs

Application of the guidelines of 40 beds per thousand population 65 and over for level II and III care and 30 beds per thousand level I care to the area population projections yields the following numbers:

Year	Population 65 +	Level II & III Beds @ 40/1000	Level I Beds @ 30/1000
1986	3729	149	112
1991	4294	172	129

Currently there are 88 level II and III beds in use at Lakeside Home in Gander and 35 level II and III beds in use at Bonnews Lodge for a total of 123 beds, or a shortfall to the guideline of 26 beds. If all beds at both facilities were utilized for level II and III care, the number of beds available for use would be 168, for a surplus in 1986 of 19 level II and III beds but a deficit of 4 beds by 1991.

Level I beds in the area include the 40 boarding home beds, 35 beds at Lakeside and 10 beds at Bonnews Lodge for a total of 85 beds. This leaves a shortfall according to the guideline of 27 beds in 1986 rising to a shortage of 44 beds in 1991. If all nursing home beds in the area convert to level II and III care, then a further 45 beds would be required.

According to the survey forms completed by the nursing homes, Lakeside Home has 19 level II and III residents from outside its catchment area. In addition are residents of Twillingate which the home considers part of its catchment area but which has been allocated to Central D for our study.

Results of surveys completed by public health nurses and district social services offices in the area yielded the following numbers:

ESTIMATED NUMBERS IN NEED OF THE FOLLOWING SERVICES

District	Nursing Home		Boarding Home		Home Care	
	S. Serv.	PHN	S. Serv.	PHN	S. Serv.	PHN
Glovertown	5-7	5	5	0	50+	30
Badger's Quay	*	6	*	10	*	23
Eastport	*	20-30	*	25-35	*	30-40
Centreville	*	5	*	1	*	8
Victoria Cove	*	3	*	1	*	0
Fogo	5	4	0	0	30	30
Gander	1	*	1	*	67	*
Carmanville	4	*	35	*	6	*
Wesleyville	6	*	6	*	35	*
Gambo	5	*	*	*	3-4	*
Musgrave Hbr	*	*	*	*	*	*
Total	26-28	43-53	47	37-47	131-132+	174-184

* Indicates that no information was received because survey was not returned, office is vacant, or no office in a particular community.

Bonnews Lodge and Lakeside Homes provided the following information on their waiting lists:

NUMBER ON WAITING LIST* BY LEVEL & LOCATION

Level	Home	Hosp	Other Nursing Home	Home of Relative or Friend	Own Home/ Sr Apt	Board. Home	Total
III	Lakeside	13	15	26	10	7	71
	Bonnews	8	4	12	3	2	29
	Subtotal	21	19	38	13	9	100
II	Lakeside	5	0	18	11	5	39
	Bonnews	3	9	11	5	7	35
	Subtotal	8	9	29	16	12	74
I	Lakeside	4	1	24	35	10	74
	Bonnews	0	1	9	13	3	26
	Subtotal	4	2	33	48	13	100
	Total	33	30	100	77	34	274

* Waiting lists do not necessarily accurately reflect those in "need" of nursing home care.

In the group discussions concerning long term care, there was a consensus that the nursing homes should become all level II and III and that personal care homes and/or congregate living facilities were required. There was also agreement that there were people inappropriately placed and that coordination of services must be given top priority. The group also agreed that it might be possible to make do with fewer beds than allowed by the guidelines provided home care services were in place and provided all services were well coordinated.

The social services questionnaire from Glovertown indicated that a home care program was in place in that area but did not identify the services provided. There are also senior citizens apartments in Eastport. The public health nurse serving Eastport identified the largest numbers requiring each category of service. Based on the distance of this area from Gander and Brookfield this area should be considered for some personal care home level I services.

Fogo Island is an extremely isolated area. Although the population is small, it requires provision of both acute and long term care services because of this isolation.

Discussion & Recommendations

Central A - Baie Verte - Springdale

Home Care/Home Support

The development of comprehensive home care and home support services should be considered a priority for the Baie Verte peninsula.

Baie Verte

There is clearly pressure for additional long term care services to meet the needs of the Baie Verte peninsula in particular. It should be noted that expansion of rehabilitation services has been recommended for Western Memorial Hospital in Corner Brook. Improved access to such services should relieve some of the pressure on long term care beds in this area. Also methods to improve access to Valley Vista beds for residents of the Baie Verte Peninsula and in particular, to patients discharged from the M.J. Boylen Hospital, should be identified. Construction of additional nursing home beds however cannot be recommended at this time. A number of actions outlined below are recommended to provide improved long term care services in the area.

The M.J. Boylen Hospital reported 31 short term beds in 1984/85 with an occupancy rate of 58.7%. Medical surgical occupancy rates were relatively high at 74.3% but the pediatric occupancy rate was only 19.3%. Obstetrical days were substantially higher than newborn days, suggesting that obstetrical beds are either being used for other types of patients or there are a large number of antenatal days. This hospital feels very pressured by a backlog of long term care patients in acute care beds.

This hospital has in recent years shared a surgeon with Springdale. The consultants have been advised that the surgeon has left this area and it is unlikely that he will be replaced. Therefore the M.J. Boylen should expect to provide fewer inpatient surgical procedures and hence fewer surgical days.

The pediatric bed complement can be reduced to 2-4 beds. If internal rearrangements can be made to accomplish this change, the pediatric room should be converted to provide lounge and recreational space for the long term care residents.

The hospital should undertake feasibility studies to determine the potential viability of outreach services from the M.J. Boylen Hospital such as day care, day hospital, meals on wheels, etc. If day care and day hospital are considered feasible, the plans for ambulatory care expansion should be revised to include staff and facilities needed for such programs.

Two respite beds should be provided in the M.J. Boylen Hospital, but with strict controls to ensure that patients return to the community.

Level I Facilities

There is a need for level I beds in this area. It is therefore recommended that 10 - 12 level I beds be developed either through licensing of a boarding home or construction of a congregate living facility. When these are fully accepted and utilized, an additional 10 beds should be considered for this area.

Springdale

This area has an adequate supply with acute and long term care beds and services. The following recommendations are made for Springdale.

Springdale Hospital has been operating at an occupancy rate of 69%. As the only surgeon has recently left this area, a reduction in inpatient utilization is anticipated. This change should permit reduction to an acute care capacity of 10 beds. In order to accomplish this recommended reduction, it may be necessary to refurbish the existing inpatient unit or construct a new nursing unit to provide multipurpose 1 and 2-bed rooms. In the short run, therefore, it may be necessary to maintain 15 beds because of the lack of flexibility in the ward system.

Valley Vista

No structural or capacity changes are recommended for this facility. Over time, the 12 beds in the nursing home now occupied by level I residents should become available for level II and III care. Adding these beds to the inventory will provide a total of 86 beds in the district (excluding 2 respite beds) which will be more than adequate according to the guidelines, until 2001. However, depending on how fast this transition occurs and on the development of the level I beds recommended in Baie Verte, there may be a need to develop additional level I beds after 1990. The need for these facilities should, therefore, be reviewed in 1990-91.

Valley Vista should be designated as the primary level II and III facility for the entire Baie Verte - Springdale health district and should co-operate with agencies in the Baie Verte peninsula to improve access to long term care services for residents of that area.

Central B - Grand Falls, Buchans, Botwood

Home Care/Home Support

Development of well organized comprehensive and continuous home care/home support services is an immediate priority for this district. It is recommended that all agencies currently involved in the provision of these services (i.e. Public Health, Central Newfoundland Regional Health Centre) and those interested in becoming involved (i.e. Carmelite House) work together and share resources, both financial and human, to facilitate the development of the best possible service.

Grand Falls

Central Newfoundland Regional Health Centre reported a total occupancy rate of 80.4% during 1984/85. However, occupancy of medical beds and psychiatric beds was very high at 92.3% and 97.9% respectively.

The high occupancy rate in medicine reflects the 12 - 20 long term care patients in the hospital at all times. When additional level II and III beds are available at Botwood, pressure on medical beds should be relieved significantly. Also the hospital has submitted a proposal to CMHC for construction of a 24 bed hostel which could be used by patients who are now being admitted for diagnostic testing which could be done on an ambulatory basis. The consultants were advised by the Executive Director that it is believed a hostel could decrease total patient days by 7000 - 8000 annually which translates into 19 - 22 beds at 100% occupancy or 23 - 26 beds at 85% occupancy.

Psychiatric occupancy in 1984/85 increased 20% over the previous year. This may reflect the fact that Grand Falls is now the centre for psychiatric care for the Central region and is therefore receiving an increased number of referrals. It is unclear whether a further increase in inpatient workload is likely. However, if the workload increases beyond that experienced in 1984/85, it will probably necessitate an increase in the number of beds. In line with Royal Commission recommendations however, no change is recommended until the Provincial plan for psychiatric services has been clarified.

Surgical occupancy decreased slightly from 80.1% in 1983/84 to 76.9% in 1984/85. The agreement between Gander and Grand Falls resulted in orthopedics being centralized in Gander and urology in Grand Falls. It would appear that this trade off should result in a balancing out of workload or perhaps a slight reduction for Grand Falls. Also, as discussed above, access to beds in Botwood for convalescent care and much needed improvement in the coordination of Home Care services should permit earlier discharge and fewer surgical patient days.

Reported obstetrical days for 1984/85 were 55.4% higher than those reported for newborns. Although it is to be expected that obstetrical days would be somewhat higher than newborn days because of the higher risk pregnancies which would be managed here than in community hospitals, it would appear that at least some portion of these days may be for women admitted from outlying areas, shortly before delivery is expected. If this is an accurate assumption, there should be potential to reduce obstetrical days through use of hostel facilities when these facilities are available.

If at some point in the future the decision is made to refer obstetrics from the Harbour Breton area to Grand Falls, the present number of beds should be more than adequate to handle the additional workload.

Based on the discussion paper on pediatrics and the recommended guideline of 1.125 pediatric beds per thousand population aged 0 - 14, Central Newfoundland region requires 39 pediatric beds in 1986, decreasing to 35 in 1991 and 30 in 2001. These would be distributed between the regional hospitals in Gander and Grand Falls.

The pediatric days and occupancy reported in the Central Newfoundland Regional Health Centre's annual return for 1984/85 indicated an increase of 1650 days and 15.1% higher occupancy over 1983/84. The consultants contacted the Hospital to determine the cause of this increase but were informed that their records for the calendar year 1984/85 indicated a decrease in patient days (January 1, 1985 - December 31, 1985 Pediatric patient days 6540, January 1, 1984 - December 31, 1984 Pediatric patient days 8718). The hospital has also reduced pediatric beds by 6 to 24, which would be adequate to accommodate the 1984/85 pediatric workload of 6540 days at 75% occupancy. In view of the current and anticipated continuing trend towards ambulatory care for pediatrics, it is recommended that this unit be sized at 22 beds or less.

The consultants are aware that another study done for the Central Newfoundland Regional Health Centre recommended a capacity of 200 beds. However we feel that based upon the development of hostel facilities, improvements in Home Care and access to long term and convalescent care beds at Botwood, there is a potential to reduce the capacity of this hospital over time to 172 beds. The requirement for inpatient psychiatric beds is, however, unclear and an increase in these beds may be required in future when the full impact of the tripartite agreement becomes obvious.

Carmelite House currently provides 83 beds for levels II and III care and 19 beds for level I care. This facility operated as a hotel prior to converting to use as a Nursing Care facility. The intent at the time of conversion, was that it would provide level I services to ambulatory residents, however, over time more and more of the residents required heavy nursing care. There is general agreement that this facility is not appropriate, with the exception perhaps of the main floor, for the primarily heavy nursing care currently being provided. With this in mind, it is recommended that planning begin for renovations to Carmelite House to provide appropriate facilities for 20 beds of level II and III care on the main floor, and a total of 73 level I beds on other floors of the building. An addition to Carmelite House to provide appropriate facilities for 15 level II and III beds is also recommended. Two extra beds for respite, emergency admissions from the community and convalescent care should also be provided.

Renovations or construction should also provide appropriate space for occupational and physiotherapy activities.

Prior to construction, there should be an assessment of the need for day hospital facilities in this area. Should it be concluded that there is such a need, and provision of a program is feasible, it is recommended that day hospital facilities be provided either through renovation or new construction.

Buchans

In view of the recent change in role from acute care to long term care, it is recommended that the staff of the A.M. Guy Hospital (including the physicians) be provided with the educational opportunities to become well oriented to, and knowledgeable about long term care. Appropriate programs must be developed and personnel such as physical, occupational and recreational therapists recruited to meet the special needs of the elderly. It is recommended that such staff be shared between Botwood, Carmelite House and the Home Care Programs in the Central B Region (at least). Finally, it is recommended that one of the beds at the A.M. Guy Hospital be formally designated for respite care.

Botwood

In advance of the opening of the new long term care facility planned for this area, it is recommended that every opportunity be taken to orient staff (including physicians), to the special needs of the elderly and the provision of long term care. Improved linkages with the Central Newfoundland Hospital and sharing of staff as discussed above are recommended to facilitate provision of the best range of services for long term care.

In view of the need for appropriately designed facilities for old age psychiatric care in the Central Region, it is recommended that such facilities be planned and designed to provide 30 - 35 beds for this purpose at the new facility in Botwood. Of the remaining 40-45 beds, two beds for respite care and emergency admissions from the community should be provided. Furthermore, to resolve the placement problems currently experienced at the hospital in Grand Falls, it is recommended that when the new facility in Botwood is opened, the hospital in Grand Falls be guaranteed priority access to 25 beds for convalescent and long term care purposes.

In the short term, one to two beds for respite should be provided at the old hospital in Botwood.

Central C - Harbour Breton - St. Albans

There are currently no facilities for long term care in Central C district. Although the hospital in Harbour Breton is in relatively good repair, it is no longer appropriate for acute care because of the large open wards and because of limited ambulatory care space. It could not be easily renovated to provide facilities for long term care and since it is situated on a very steep and exposed site, this would preclude its use for this purpose.

Because of the isolation of many of the communities in this district, particularly along the coast, there will always be a need to provide acute care facilities of some sort. In the long run, it is recommended a new facility to meet the needs for acute and long term care be constructed in this district.

The projected population of Central C district would support approximately 30 - 40 beds for level II - III care and it is recommended that 10 beds for acute care, ambulatory clinic facilities and possibly office space for Public Health and Social Services be located within the same structure.

In the short term however, it is recommended that Central C be developed as a test site for the provision of comprehensive home care/home support services. During the meeting held to discuss long term care requirements in this district, there was unanimous agreement that the development of comprehensive, continuous home care services for the communities in this district was the number one priority. (Note that a small pilot project for Home Care was being run through Harbour Breton Hospital this winter and was very well received.) It is suggested that these services be developed utilizing non professional personnel (who have received some basic training in personal and nursing care) living in each community under the supervision of a professional person such as a Public Health Nurse or Home Care Coordinator.

Further discussion is required regarding the feasibility of a Meals on Wheels service but it was clear from discussion at the regional meeting that handyman and home help services should be considered for the elderly in this area.

Adequate funding to ensure provision of consistent, reliable services is absolutely essential to the success of this pilot project. If insufficient funding is provided and services are not deemed reliable by health care personnel and residents of this district, more costly institutional services will be considered the only choice.

Within the next 1 - 2 years, planning should begin for the construction of the acute care and ambulatory clinic phase of the health care centre described above, allowing for addition of long term care facilities in the future. Two beds should be formally designated for respite and convalescent care and emergency admissions from the community. In the short term, two beds at the hospital in Harbour Breton should be formally designated for this purpose.

A complete evaluation of the impact of home care services on the need for institutional beds for long term care should be carried out before the long term care facilities are developed in this district since it is anticipated that these services will lessen the need for such beds. This evaluation should be done 2 - 3 years following the establishment of comprehensive home care/home support to communities in the district.

Level I Facilities

Home care and home support services may also affect the need for level I services. The projected population of Central C district could support up to 27 level I beds by 1991, however in view of the recommendation to establish comprehensive home care, it is recommended that approximately 12 - 15 beds be provided when funds permit and that before additional facilities are developed, an evaluation of the impact of home care/home support on the need for level I services be carried out.

Central D - Lewisporte - Twillingate

Home Care/Home Support

The development of comprehensive home care and home support services should be a priority throughout the district.

Lewisporte

North Haven Manor operates at an occupancy rate of 100%. It has started a number of outreach programs but these are limited. Expansion to provide adequate space for occupational and physiotherapy will be required.

Provision of additional beds at this facility is dependent on a number of other factors in this district and in Botwood. There will be a deficit of 20 level II - III beds in this district in 1991. If these can be reasonably added to the Twillingate Hospital as discussed previously, a better distribution of beds throughout the district would be achieved.

However, if after further review, it is considered best to add these beds to an existing long term care facility, they should be added to North Haven Manor.

Further discussion may also be required concerning provision of old age psychiatric services in this area. Beds for this type of care have been recommended on a regional basis. There is an existing unit in Gander and a 30-35 unit in the facility to be constructed in Botwood has been recommended. Together, these will meet the needs identified for Central Newfoundland. If, however, the unit in Botwood is not developed, consideration should be given to expanding North Haven Manor to include a 25-30 bed unit for old age psychiatric care. This home has expressed interest in developing such services.

Level I Facilities

The licensed boarding home in Porterville is the largest such facility in the province and is not in keeping with the current philosophy of small personal care homes. There are currently 6 vacancies in this home. Therefore, it is recommended that the Welfare Institutions Licensing Authority review the capacity of this home to ensure there is adequate space for the number of residents accommodated. If this review results in a reduced capacity, the beds should be reallocated to other facilities in the district. The need for additional level I beds should be evaluated.

All level I facilities in this district should operate in close co-operation with North Haven Manor in Lewisporte.

Twillingate

Although this area was promised a nursing home facility, the consultants do not recommend development of a nursing home in Twillingate. While there is a shortfall of 8 level II and III beds in this district in 1986 rising to 20 beds in 1991, this shortfall is relatively less than in other areas of the province and does not justify development of a free-standing facility.

Reallocation of beds and staff from acute care to long term care in the hospital in Twillingate is one alternative, although in view of this role change, a significant effort would be necessary to orient staff to the provision of long term care rather than acute care. Another alternative would be to add the required beds to North Haven Manor in Lewisporte.

The following discussion and recommendations relate to the Twillingate area.

Notre Dame Bay Memorial Hospital has been operating at an occupancy rate of approximately 50% for its acute care beds. There is a 4-bed ICU which also doubles as the recovery room at this hospital. Utilization of this facility is low. In view of the less than optimal occupancy in the medical surgical unit (62% in 1984-85) maintenance of a separate ICU would not appear justified. A two-bed room equipped with monitoring equipment in the medical-surgical unit should meet the needs for critical care in this hospital.

Obstetrical workload has been declining consistently. The hospital reports 6 beds for obstetrics, but in fact 4 beds would be more than adequate to serve the 1984/85 workload. A continued decline is anticipated in future both as a result of declining birth rates and as a result of changing patterns of practice. A reduction to 4 obstetrical beds is recommended now, with further reductions anticipated in future.

Pediatric workload has been declining and consistent with other areas of the province, this hospital should not continue to provide a separate pediatric unit. Provision of a pediatric room in the medical-surgical unit should meet the needs.

Following are the consultants' specific recommendations concerning Notre Dame Bay Memorial Hospital:

1. The acute care capacity of this hospital should be reduced from 54 to 37 beds. This should be accomplished by relocating intensive care to a 2 bed room in the medical unit and closing the pediatric unit. A pediatric room should be provided in the medical/surgical unit.

2. The hospital should examine the feasibility of providing up to 20 additional beds for long term care in space reallocated from acute care. If feasible, space and staff should be reassigned to long term care. If new construction is required to provide 20 long term care beds, capital and operating costs should be compared to the cost of adding 20 beds to North Haven Manor in Lewisporte.

3. In view of the change in role, staff should be well oriented to provision of long term care and programs for residents of the long term care unit should be improved (i.e. recreation programs developed, etc.). Two - three beds should be designated for respite and convalescent care and emergency admissions from the community.

Level I Facilities

The deficit of level I facilities in the district reflects a lack of such facilities in the Twillingate area. It is therefore recommended that up to 12 level I beds be provided either in congregate housing or personal care homes in the Twillingate area. The need for additional level I beds in this area should be evaluated.

Central E - Gander, Fogo, Brookfield

Home Care/Home Support

There are a number of home care programs operating in Central E district. Priority should be given to the coordination and expansion of these services to cover all parts of the district.

Gander

Home Care/Home Support

The consultants were advised that efforts to assess the need for Home Care/Home Support services in this area are currently underway. Assuming that there is a demonstrated need for these services, they should be developed as a priority.

In 1984-85, the James Paton Memorial Hospital reported 162 beds set up, although during the consultants' visit the operating capacity was 157. The distribution is as follows:

Service	Reported on Annual Return	Reported During Visit
Medical	34	34 (includes cardiac stepdown)
Surgical	58	58
ICU	4	4
Obs	23	18
Psychiatric	14	14
Pediatric	29	29 (12-15 open; remainder under construction)
	162	157

The occupancy rate of the medical beds has been exceedingly high with the result that frequently medical patients are admitted to surgical beds. Sometimes this situation influences the ability to maintain surgical schedules. The opening of beds at Lakeside Homes provided some relief by admitting a number of the hospital's long stay patients.

Provision of better organized services for diagnostic testing, together with a hostel should encourage reductions in inpatient medical admissions. The hospital should continue to seek ways to reduce medical patient days to live within the beds provided.

The surgical patient days have been increasing over the past few years. A significant portion of the increase in surgery is related to orthopedics, a specialty in which lengths of stay are relatively longer than other specialties (e.g. ENT, Ophthalmology). While orthopedic workload is expected to increase as a result of the tripartite agreement, urology, another relatively long stay specialty, should decrease. A shortage of OR time is also causing pressure on surgical beds. This problem should be corrected. In consideration of the recommended hostel and continuing reductions in length of stay anticipated in the surgical specialties, no changes are recommended in the surgical capacity at this time.

Although the hospital continues to report 23 obstetrical beds on the annual return, there were only 18 beds in operation at the time of the consultants' visit. Based on obstetrical patient days used in 1984-85, 16 beds would be adequate to operate at 65% occupancy. Reductions should be possible in this service in future in view of the recommended hostel. Therefore in future, 14 beds should be adequate for obstetrics.

Based on the discussion paper on pediatrics and the recommended guideline of 1.125 pediatric beds per 1000 population aged 0 - 14, Central Newfoundland region requires 39 pediatric beds in 1986, decreasing to 35 in 1991 and 30 in 2001. These would be distributed between the regional hospitals in Gander and Grand Falls. Historical workload in Gander has been declining, and 17 beds would be adequate to accommodate the 1984-85 pediatric days at 75% occupancy.

In view of the declining occupancy in pediatrics, the hospital has recently undertaken renovations to provide an adolescent unit. Therefore, the upper age limit for the unit will be increased. The remaining pediatric ward is not conducive to bed reductions because of the open ward layout. However, in the long run, renovations will be required to provide for modern concepts of pediatric care (i.e. care by parent, etc.). Although 20 beds should be an ample capacity for pediatrics in the short run, reduction to this capacity is not expected to produce substantial cost savings. Therefore, when redevelopment of the pediatric unit is planned, it should be reduced to a capacity of 16-18.

The 14-bed (operating at 10) psychiatric unit is expected to close when Psychiatry is centralized at Central Newfoundland Regional Health Centre. This unit will then become available for other uses. In view of the need identified for rehabilitation services to serve Central Newfoundland, and because of other resources available in Gander (orthopedics, physiotherapy, etc.), it is recommended that the rehabilitation unit for the region be located at the James Paton Memorial Hospital. Consideration should be given to the feasibility of locating this service in the vacated psychiatric unit. If this area is not suitable, then other renovations and/or new construction should be considered. The rehabilitation program should include inpatient, day hospital and outpatient clinic services and should include a multi-disciplinary team including rehabilitation nurses, physiotherapists, occupational therapists, speech therapists, social workers, etc.

The exact size of the rehabilitation unit will require further study and will depend to some extent on the availability of space and funding as well as the extent to which day hospital services are an appropriate alternative to inpatient care in this region. In the short run, the consultants recommend developing 10-12 beds for rehabilitation with the potential to expand to 18-20.

Therefore the recommended capacity for this hospital is 134 acute care plus 10-12 (rising to 18-20) rehabilitation beds, with the distribution of the acute care beds to be determined by the hospital.

Lakeside Homes recently expanded its capacity by 50 beds, of which 25 are designated for old age psychiatry. However, inadequate space was provided in the new old age psychiatry unit. It is recommended that the capacity of the unit be reduced to approximately 20 beds to provide adequate space. Further program development is also required for residents of this unit.

In addition to reducing the capacity to provide adequate space as discussed above, it is recommended that 2 beds at Lakeside Homes be formally designated for respite and up to 5 beds designated for short term emergency placements and convalescent care.

Finally, it is recommended that new admissions be restricted to level II and III care.

Fogo

There are currently no home care or long term care services on Fogo Island. As a result hospital patient days are undoubtedly higher than they should be. Fogo Hospital is an 18 bed acute care facility which operates at slightly more than 30% occupancy. This facility will need to be replaced within the next 5 - 10 years and when it is, a multi-purpose health care centre with inpatient and outpatient services for acute and long term care should be provided. Consideration should also be given to providing space for public health and social services personnel and any other services appropriately located in the centre. When new facilities are built, the acute care capacity should not exceed 6 beds. The number of long term care beds will depend on the evaluation of home care services recommended below.

In the short term however, it is recommended that Fogo Island be developed as a test site for comprehensive home care/home support services. As discussed in relation to similar projects in Western A and Central C, it is essential that these services be fully funded to ensure that a consistent, reliable alternative to institutional care is provided. If such services can be effectively provided, it is anticipated that fewer beds than recommended by the norms of 40 and 30 beds/thousand population 65 years and over for levels II - III, and I respectively may be required (i.e. 10 beds for level I and 12 beds for level II - III). The impact of home care services on the requirement for levels I, II and III beds should be fully evaluated before their development in this area. In the short term, it may be appropriate to develop 3 - 6 level I beds under the auspices of the hospital (although not necessarily on the same site).

Brookfield/Valleyfield

Home Care/Home Support

A home care program is currently provided through the Brookfield Hospital. Home care and home support services should continue to be developed in this area consistent with the overall provincial plan.

Brookfield Hospital is a 30 bed hospital operating at an occupancy rate of approximately 45%. There is a need for improved ambulatory care facilities here which may be accomplished through renovation and/or new construction. When this is done, the acute care capacity should be reduced to 10 beds.

Additional level II and III beds are not required in this area at this time. At least two beds should be designated for respite and short term emergency placements at Bonnews Lodge. As level I beds become vacant, they should be filled with level II and III residents so that they will eventually become 100% level II and III.

Level I Facilities

The statistical shortfall of level I beds in 1986 is 27. Provision of 3-6 beds in Fogo should be considered in the short run, increasing to 10-12 if home care/home support services do not meet all the needs.

Because of the apparent need as identified by the public health nursing questionnaire for the area around Glovertown and Eastport, it is recommended that up to 20 level I beds be provided in this area. Ideally, these would be closely linked to the Gander and District Hospital Board. As Lakeside Home and Bonnews Lodge gradually eliminate their level I beds, replacement level I facilities should be provided in those areas.

Central Region

SUMMARY OF PRESENT CAPACITY* AND RECOMMENDED CAPACITY**

District/Facility	Total Capacity (1985/86)	Recommended Capacity				
		Acute (2001)	Rehab (1991)	Level II & III (1991)	Level I (1991)	Respite** (1991)
Central A						
M.J. Boylen Hospital	39	25-27		8		2
Springdale Hospital	25	10				
Valley Vista	104			90	12	2
Personal Care Beds					10-12	
Subtotal		35-37		98	22-24	4
Central B						
Central Newfoundland Reg. Health Centre	208	172				
Carmelite House	102			35	73	2
Botwood	46			73		2
A.M. Guy Hospital	20	2		17		1
Personal Care Beds	20				20	
Subtotal		174		125	93	5
Central C						
Harbour Breton Hosp.	19	0		0	0	0
New facility		10		30***		2
Personal Care Beds	0				12***	
Subtotal		10		30	12	2
Central D						
Notre Dame Hospital	69	37		34****		2-3
North Haven Manor	76			74		2
Personal Care Beds	44				56	
Subtotal		37		108	56	3

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District/Facility	Total Capacity (1985/86)	Recommended Capacity				
		Acute (1991)	Rehab (1991)	Level II & III (1991)	Level I (1991)	Respite** (1991)
Central E						
James Paton Hospital	157	134	10-12 (+8-10)			
Lakeside Home	123			111		7
Brookfield Hospital	30	10				
Bonnews Lodge	45			43		2
Fogo Hospital	18	6		10*****		2
Personal Care Beds	40				66	
Subtotal		150	10-12	164	66	11
Grand Total (Recom'd Capacity)		406-408	10-12	525	249	26-27
(Present Total Capacity)		(546)	(0)	(381)	(208)	(5)

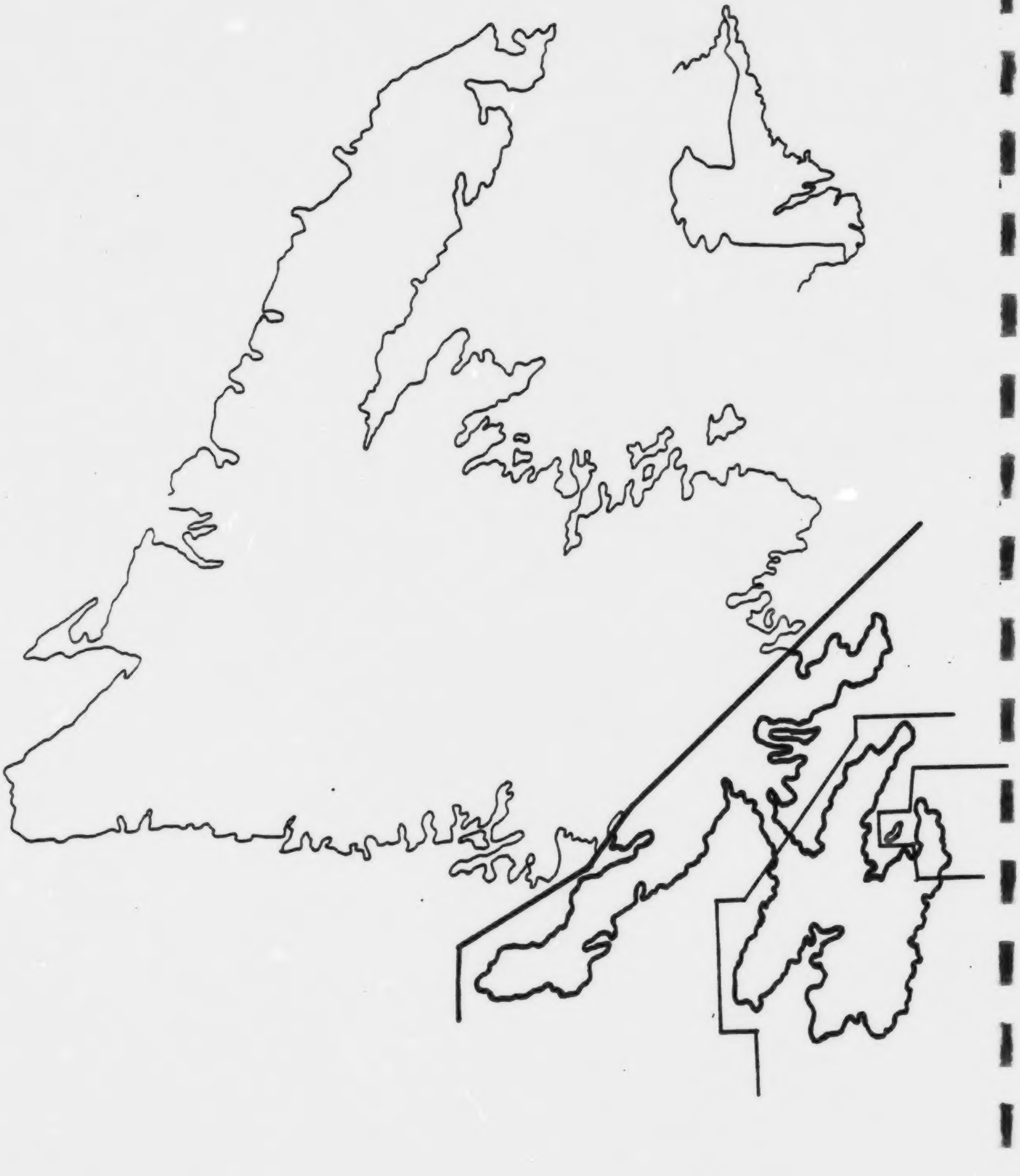
* Present capacity based upon beds open at time of Consultants visit or on information received since visit.

** Includes convalescent and emergency use.

*** The number of beds for level I, II, and III may be reduced depending upon the success of comprehensive home care/home support services.

**** Increased capacity will depend on feasibility of reallocating acute care resources to long term care.

***** This number may be reduced depending on success of comprehensive home care/home support services.



Eastern Region

General Description

The Eastern Region includes the eastern portion of the island of Newfoundland from Terra Nova National Park to St. John's. It is divided into three sub-regions known as Eastern 1 - St. John's and Greater St. John's, Eastern 2 - the Avalon Peninsula outside St. John's and Eastern 3 - Burin - Bonavista. Each of these sub-regions has been further subdivided into districts for purposes of planning long term care services, as follows:

Eastern 1:	Eastern 1A - Eastern Avalon outside St. John's Eastern 1B - St. John's, Greater St. John's
Eastern 2:	Eastern 2A - The Bay de Verde Peninsula Eastern 2B - Southwestern Avalon
Eastern 3:	Eastern 3A - Bonavista Peninsula Eastern 3B - Burin Peninsula Eastern 3C - Clarenville, Come by Chance

For many years people in this region received primary health care through clinics and cottage hospitals established in several communities, with all regional and tertiary care provided in St. John's. This pattern is slowly changing with the establishment of regional hospitals providing specialty care in Carbonear (1976), Clarenville (to open 1986) and Burin (under construction).

Development of specialty services and changes in referral patterns inevitably occur over a number of years. Therefore, many specialty services are still provided in St. John's which should eventually be provided in one of the regional centres outside St. John's. The impact that development of specialty services in regional centres will have on referrals to St. John's and hence bed requirements should be evaluated over time .

Over 50% of the total population of Newfoundland and Labrador resides in the Eastern Region. Although it contains isolated communities such as St. Brides, Branch and Point May, it is generally a more densely populated region than the other regions in Newfoundland and Labrador. Also, people have become accustomed to traveling to St. John's for health care and other services, a pattern which may change slowly as services develop outside St. John's.

Health Problems

The health problems of this region are similar to the rest of Newfoundland and Labrador with cardiovascular disorders, hypertension, diabetes and malignancies being the major groupings of people in need of care.

Inventory of Health Care Services

This region contains all of the tertiary care facilities in the province, one regional hospital with specialty services and a second one due to open soon, 8 small community hospitals, 13 nursing homes and 48 licensed boarding homes (excluding the Waterford Homes). Following is an outline of the services available in each area.

Eastern 1A - Eastern Avalon

Hospitals

The only hospital in this district is the Dr. Walter Templeman Hospital on Bell Island. This is a 40-bed acute care facility which recently became the responsibility of St. Clare's Mercy Hospital in St. John's. It does not formally provide any long term care services, but it is the consultants' understanding that several long term patients are in fact accommodated here. Also, consideration is being given to formal designation of some beds for long term care.

Nursing Homes

There are no nursing homes in this district. Persons requiring level II and III care generally seek services in St. John's.

Home Care

The consultants were not advised of any formalized home care services in this area. The VON provides services in some communities in the immediate vicinity of St. John's and Public Health nurses provide limited services where possible in the rest of the district.

Licensed Boarding Homes

There are 529 licensed boarding home beds in this district. Following is a summary of these beds:

Licensee	Location	Licensed Capacity
Barton	Goulds	13
Butler	Kelligrews	12
Canning	Manuels	36
Chafe	Petty Harbour	7
Coady	Torbay	12
Crawley	St. Mary's	15
Dinn	Mt. Carmel	15
Dinn	Witless Bay	28
Dunne	Mount Pearl	5
Fahey	Fermeuse	20
Glynn	Bay Bulls	13
Halliday	Manuels	17
Hennessey	Kilbride	12
Kelly	Goulds	16
Keough	Holyrood	26
Kirby	Holyrood	15
Lewis	St. Mary's	19
Maloney	Goulds	4
Murphy	Paradise	15
O'Neill	Goulds	11
Pardy	Kelligrews	17
Pennell	Trepassey	18
Perrin	Long Pond	35
Piercey	Kelligrews	19
Quinlan	Holyrood	16
Smith	Kelligrews	20
Sturge	Mount Pearl	17
Walsh	Bay Bulls	10
Wettlaufer	Foxtrap	14
Woodford	Holyrood	9
Woodford	Holyrood	43
	Total	529

In addition to these licensed boarding home beds are the 282 beds in Community Care ("Waterford") boarding homes.

Eastern 1B - St. John's, Greater St. John's

Hospitals

In St. John's there are 6 tertiary care hospitals all of which are involved in formal and informal teaching programs for medical and other health science students. Following is a brief summary of the services provided by each of these institutions.

Health Sciences Centre

This is a modern teaching hospital containing 342 adult acute care beds including 20 psychiatric beds. It is the designated trauma centre for the province and provides a number of subspecialty services. It also administers the Miller Centre, a 204-bed facility providing rehabilitation, convalescent, old age psychiatry and long term care services. The bed distribution of the Miller Centre is as follows:

Special Rehabilitation	20
Continuing Care	29
Geriatric	30
Old Age Psychiatry	35
Veterans	69
Convalescent (closed for financial reasons)	21

The Grace Hospital is a 292-bed acute care facility of which 25 beds are provided for psychiatry. It provides a number of specialty services including obstetrics, for which it has been designated the high risk referral unit for the province. This hospital is planned for replacement on a site adjacent to St. Clare's Mercy Hospital.

This hospital provides primary and secondary (i.e. regional) services to residents of the Eastern Region as well as selected tertiary care services to the entire province.

St. Clare's Mercy Hospital is a 323-bed acute care facility of which 24 beds are provided for psychiatry. It provides a number of specialty services at the secondary level for the region and selected tertiary care services for the province. An expansion and renovation program is being planned as part of the overall development to include the Grace and Janeway Hospitals. This hospital is also administratively responsible for the Dr. Walter Templeman Hospital on Bell Island.

The Waterford Hospital is a psychiatric facility providing inpatient and outpatient services to adult patients with psychiatric disorders. It provides acute, long term and old age psychiatric services as well as residential services for the mentally handicapped. It is also responsible for the administration of 23 community care boarding homes containing 282 beds located in Conception Bay South.

Dr. Charles A. Janeway Child Health Centre is the pediatric referral centre for the entire province and the only pediatric acute care facility in St. John's. It contains 193 beds of which 13 are designated for psychiatry. Plans to relocate this institution on a site adjacent to St. Clare's Mercy Hospital are being considered.

The Children's Rehabilitation Centre is a 42-bed facility providing inpatient and outpatient rehabilitation services to children with disabilities. It is the only such facility in the province and therefore acts as the referral centre for disabled children living in all parts of the province. The majority of its services are provided on an outpatient basis and therefore in practice, only 10-12 beds are in use at any one time. Plans to relocate this facility to the same site as the Janeway Child Health Centre are under consideration. If and when such relocation occurs, the bed capacity will be reduced considerably.

Nursing Homes

There are 7 nursing homes in St. John's with a total of 1034 beds. The Agnes Pratt Home recently received approval to construct an additional 70 beds which will raise the total number of beds to 1104. These are located in the following facilities:

Home	Capacity
Agnes Pratt	66 (+70)
Escasoni	191
Glenbrook Lodge	140
Hoyles Home	249
Masonic Park	42
St. Luke's	132
St. Patrick's Mercy Home	214
Total	1034 (1104)

Home Care

Home care is provided through the St. John's Home Care Program which provides nursing, physiotherapy, homemaker and other services to residents of St. John's. There is a need to improve and expand services for acute and long term care available through this program.

Boarding Homes

There are no boarding homes located in St. John's although there are a great many located in close proximity to St. John's. These were identified in the previous section.

Eastern 2A - The Bay de Verde Peninsula

There are two hospitals, three nursing homes and 11 boarding homes located in this district. Following is a brief description of each.

Carbonear

Carbonear General Hospital is a 100-bed acute care hospital of which 86 beds are currently in operation. There is potential to expand to 124 beds without construction. Specialties currently available include internal medicine, general surgery and obstetrics. The hospital plans to recruit a pediatrician, psychiatrist and additional internists. Subspecialty consultation services are available in St. John's.

The Interfaith Citizens Home in Carbonear is a 55-bed nursing home providing level III care. It is located in the building formerly occupied by the hospital. Twelve of the 55 beds are occupied by young handicapped adults. The Home provides meals on wheels and a day care program. Wheels to meals is under consideration. Respite care is provided (2 beds). It provides selected supplies such as incontinent pads to discharged patients being cared for at home.

Harbour Lodge is a 98-bed provincially owned and operated nursing home providing level III care. As a provincial facility, residents are admitted from the entire province. All residents require heavy (level III) care. A 50-bed expansion is currently under construction.

Home Care

A limited home care program is provided by Carbonear General Hospital to patients in the immediate area. Limited homemaker services are available through Social Services.

Other Facilities

There is one 15 bed licensed boarding home located in Carbonear.

Old Perlican

Old Perlican Hospital is a 15-bed acute care hospital operated by the Trinity Conception Bay Board which also administers the Carbonear General Hospital. Also included in Old Perlican is an 8-bed Developmental Maximization Unit for severely disabled children. No surgery or deliveries are performed here. The building is in a good state of repair, although it is of typical cottage hospital design with large open wards.

Other Facilities

There are no nursing homes in Old Perlican. There is, however, one 20-bed licensed boarding home.

Clarkes Beach

The Pentecostal Senior Citizens Home at Clarke's Beach is a 102-bed nursing home opened in 1967. 52 residents were level II and III, while 49 were reported as level I on the survey undertaken by the consultants. No day care, outreach or respite services are provided by this institution. Included in this facility are two 11-bed rooms and one 4-bed room which are overcrowded.

Other Areas

There are several licensed boarding homes in this district as follows:

Name of Licensee	Location	Beds
Barrett	Old Perlican	20
Chaulk	South River	26
Earle	Shearstown	12
Gosse	Spaniard's Bay	15
Legge	Whiteway	15
Marshall	Brigus	30
Marshall	Brigus	8
Norman	Bay Roberts	6
Tetford	Shearstown	16
Wareham	Carbonear	15
Wilcox	Shaw's Lane	8
		171

Eastern 2B

Placentia

Placentia Cottage Hospital was opened in 1942 and has a rated capacity of 35 acute care beds. In fact, it operates with 32 beds distributed as follows:

Male Ward	8
Female Ward	8
Obstetrical	7
Pediatric	7
Private Rooms	2
Total	32

Lions Manor is a new 75-bed nursing home which is planned to open during the spring of 1986. Initially, it will provide levels II and III care with 2 beds reserved for respite. Plans for the near future include development of home care, day care, meals on wheels, wheels to meals, friendly visiting and senior citizens cottages.

Home Care

There is no formalized home care in this area at the present time.

Boarding Homes

There is one 20-bed licensed boarding home located in Dunville.

Eastern 3A - Bonavista Peninsula

With the exception of the medical clinics located outside the town of Bonavista, all health care facilities serving this catchment population are located in Bonavista at the northeastern tip of the Bonavista peninsula. These facilities are as follows:

The Bonavista Cottage Hospital is a 25-bed hospital completed in 1984. Currently 15 of the 25 beds are staffed and in operation. These are comprised of 12 adult beds and a 3-bed pediatric crib room. An additional 10 beds are unopened in the hospital. These were supposedly designed and intended for long term care. However, their location as a separate unit and the lack of a home like environment in the unit makes them less than ideal for long term care.

Golden Heights Manor is a 47-bed nursing home located several blocks away from the hospital. A 40 bed addition was recently approved for this facility. On the survey of nursing homes, this home reported that it accommodated 35 level III, 11 level II and 1 level I residents. It does not currently provide respite. Twenty senior citizens cottages are administered by the home. Meals on wheels and home care are provided by the home. A day care centre with a capacity of 12 - 15 is planned to open in the spring of 1986.

Other Areas

There is a 4-bed licensed boarding home in Port Rexton. There is also a 20-bed boarding home in Musgravetown and a 17-bed boarding home in Lethbridge. These latter two are located at the lower end of the peninsula, closer to Clarenville than to Bonavista. They are considered as serving both the Clarenville and Bonavista districts. However, for the purpose of this inventory, they are included in district 3C.

Eastern 3B - Burin Peninsula

There are currently three acute care hospitals in this catchment area which are due to close when the new 75-bed hospital opens in Salt Pond. There is also a nursing home in Grand Bank. Following is a brief description of each of these facilities.

Burin

The Burin Hospital is a 31-bed acute care facility. It does not provide any long term care programs, but does from time to time have beds occupied by long term care patients. Occasionally, it provides informal respite services.

St. Lawrence

The U.S. Memorial Hospital is a 22-bed acute care hospital. No beds are designated for long term care, but the hospital generally has one or more long term care patients at all times. Respite is provided on an informal basis occasionally.

Grand Bank

The Grand Bank Hospital is a 31-bed acute care facility. No beds are designated for long term care, but informal respite is provided on occasion.

The Blue Crest Interfaith Home in Grand Bank is an 86-bed nursing home with an additional 8 level I beds provided in an annex. Respite care is not currently provided. Ten senior citizens cottages are under construction. A home care program is offered by the home.

Salt Pond

The new hospital under construction in Salt Pond will provide 60 acute care and 15 long term care beds. It will replace the cottage hospitals in Burin, St. Lawrence and Grand Bank all of which are outdated and unsuitable for continued use for acute or long term inpatient services.

Other Facilities

There are no licensed boarding homes in this district. However, there is a group home for mentally handicapped children located in the district.

Eastern 3C - Clarenville, Come by Chance

Come by Chance

The Come by Chance Hospital is a traditional style cottage hospital rated at 24 beds. It is comprised of two 10-bed wards and a pediatric room with 4 cribs. This hospital is planned to close as an inpatient facility when the new Clarenville Hospital opens.

Clarenville

The Dr. G. B. Cross Hospital is a brand new facility of 60 acute care and 15 long term care beds which is not yet providing inpatient services. It is anticipated that selected inpatient services will begin in late spring or early summer of 1986. The hospital will be staffed by a full complement of general practitioners plus specialists in internal medicine, obstetrics, anaesthesia, surgery and pediatrics.

Other Facilities

There are no nursing home beds in this district.

There are no formalized home care programs in this area at present. However, the G. B. Cross Hospital plans to develop home care services as resources become available.

There is one 32-bed licensed boarding home in Clarenville.

Other Areas

There are a total of 89 licensed boarding home beds in the area in the following locations:

Licensee	Location	Licensed Beds
Fewer	Clarenville	32
Greening	Musgravetown	20
Moss	Lethbridge	17
Blundon	Hickman's Harbour	20
	Total	89

As discussed in the Bonavista section of this report, the beds located in Musgravetown and Lethbridge can be considered to serve both the Bonavista and Clarenville districts. Therefore, 20 of these beds have been assigned to the Bonavista district and 17 beds to the Clarenville district. The number available to the Clarenville district is therefore considered to be 69.

Population

Statistics from the 1981 census provided the following information on the population of the Eastern Region.

Health District	0-14	15-64	65-75	75+	Total
Eastern 1A Eastern Avalon	13,498	27,949	2,522	1,131	45,100
Eastern 1B St. John's, Greater St. John's	33,500	87,492	7,980	2,910	131,882
Eastern 2A Bay de Verde Peninsula	10,580	23,392	2,792	1,486	38,250
Eastern 2B Southwestern Avalon	6,268	12,457	1,124	596	20,445
Eastern 3A Bonavista Peninsula	4,440	10,125	1,315	735	16,615
Eastern 3B Burin Peninsula	8,400	15,390	1,230	670	25,690
Eastern 3C Clarenville, Come by Chance	8,225	16,305	1,750	945	27,225
Total	84,911	193,110	18,713	8,473	305,207

The projected future populations for the Eastern Region are as follows:

Year	Total Pop.	0-14	%0-14	65+	%65+
1986	308,466	79,249	25.7	30,200	9.8
1991	319,772	74,858	23.4	34,336	10.7
2001	322,776	67,816	21.0	39,616	12.3

Assessment of Needs

Acute Care

The guidelines of 3.5 - 4.0 beds per thousand population were considered by the consultants to be a useful starting point in determining beds required for acute care. A review of current and anticipated future practices, however, indicated that approximately 10% of the services required will be of a tertiary nature such as can only be obtained in St. John's. Therefore, the actual guidelines which have been used are 3.15 to 3.6 acute care beds per thousand population for primary and secondary hospital beds. The remaining 0.35 - 0.40 beds per thousand population for tertiary care have been applied to the total provincial population and allocated to St. John's.

Pediatric beds in designated pediatric units have been determined by applying the norm of 1.125 beds per 1000 aged 0 - 14 to the regional population and have been considered as part of the total inventory of acute care beds. An additional 0.375 beds for tertiary pediatric care have been allocated to the provincial population aged 0-14 and have been allocated to the Janeway Child Health Centre in St. John's. (For explanation of this formula refer to the discussion paper on Pediatrics in the appendices to this report.)

Application of the guidelines to the population of the Eastern Region yields the following numbers.

Year	Total Pop.	Acute Care Beds @ 3.15-3.6/1000	Pop. 0-14	Ped Beds @ 1.125/1000	Acute Care Beds Req'd (excl Peds)
1986	308,466	972 - 1110	79,249	89	883 - 1021
1991	319,772	1007 - 1151	74,858	84	923 - 1067
2001	322,776	1017 - 1162	67,816	76	941 - 1086

Application of the tertiary care bed allocations to the provincial population yields the following additional numbers to be allocated to St. John's:

Year	Prov. Pop.	Total Acute @ 0.35-0.40/1000	Prov. Pop. 0-14	Ped Beds @ 0.375/1000	Acute Care Beds Req'd (excl Peds)
1986	581,347	203 - 233	155,844	58	145 - 175
1991	595,044	208 - 238	144,288	54	154 - 184
2001	602,031	211 - 241	125,867	47	164 - 194

Adding the regional and tertiary care requirements together yields the following numbers:

Year	Adult Beds			Pediatric Beds			Grand Total
	Region	Tertiary	Total	Region	Tertiary	Total	
1986	883-1021	203-233	1086-1254	89	58	147	1233-1401
1991	923-1067	208-238	1131-1305	84	54	138	1269-1443
2001	941-1086	211-241	1152-1327	76	47	123	1275-1450

Based on the beds reported as staffed and in operation by the hospitals when visited by the consultants, there are a total of 1445 acute care beds in the region (excluding beds at the Waterford, Children's Rehabilitation Centre, the Miller Centre and the unopened beds in Clarenville). Although the convalescent beds at the Miller Centre should be considered part of the acute care inventory they have not been counted for purposes of this calculation. Therefore, there is a surplus to the guideline of 44 - 212 beds in this region. This surplus will decline to 6 - 181 by 1991 provided that the cottage hospitals designated to close do so when beds are opened in new facilities in Clarenville and Burin/Salt Pond, and provided beds in St. John's are limited to 1185 as recommended by the Royal Commission.

Since this region has both the greatest population and the largest inventory of alternative services such as nursing home and boarding home beds and home care, it should be operating at the lower end of the bed range.

Rehabilitation

As indicated in section 10.2 of this report, there is a shortage of rehabilitation beds and services throughout Newfoundland and Labrador. The 20-bed special rehabilitation and the 30-bed general rehabilitation units at the Miller Centre are the only units outside Corner Brook and therefore serve most of the province. General rehabilitation units have been recommended for other regions and the development of these will affect the bed requirements at the Miller Centre.

The Miller Centre will remain the only unit for special rehabilitation. It should, therefore, continue to be considered as a provincial referral centre.

No formula has been recommended for special rehabilitation since the consensus across the province was that the need for this type of service was being reasonably well met at the present time. Since the prevalence of disorders (e.g. trauma) requiring this type of rehabilitation is not anticipated to increase, the current number of beds should remain adequate for the foreseeable future.

The guideline recommended for general rehabilitation to be applied to regional populations is 0.2 beds per 1000 population. Applying this norm to the 1986 population of Eastern Region yields a requirement for 62 beds in 1986, rising to 64 beds in 1991. The need for this services will increase as the number of elderly increases since it is the older age groups who most often require this type of care.

Long Term Care

Eastern 1A - Avalon

The 1981 census population of this area was as follows:

Health District	0-14	15-64	65-74	75+	Total
Bell Island	1,475	2,985	305	95	4,860
Eastern Avalon	12,023	24,964	2,217	1,036	40,240
Total	13,498	27,949	2,522	1,131	45,100

Newfoundland Bed Study - 8514

Projections to 1991 and 2001 provided for the Royal Commission for the Eastern Region were broken down into health districts by the consultants. The projected future populations for this area are as follows:

Year	Total Population	Population 65 +	% 65 +
1986	48,957	4,259	8.7
1991	52,813	4,865	9.2
2001	51,042	5,643	11.1

Application of the guidelines of 40 beds per 1000 population 65 years and over for level II and III care and 30 beds per 1000 for level I care to the area population projections yields the following numbers:

Year	Population 65 +	Level II & III Beds @ 40/1000	Level I Beds @ 30/1000
1986	4,259	170	128
1991	4,865	195	146

According to the guidelines, there is, therefore, a current deficit of level II and III beds of 170 beds, rising to 195 beds by 1991. There is a surplus of 401 level I beds now.

Results of surveys completed by public health nurses and district social services offices yielded the following numbers:

ESTIMATED NUMBERS IN NEED OF
THE FOLLOWING SERVICES

District	Nursing Home		Boarding Home		Home Care	
	S. Serv.	PHN	S. Serv.	PHN	S. Serv.	PHN
Holyrood	*	3	*	7	*	25
Topsail	*	3	*	3	*	3
Long Pond	*	0	*	0	*	25
Foxtrap	*	5	*	3	*	9
Bell Island	*	10	*	0	*	6
St. Mary's	*	10	*	15	*	25
Seal Cove	*	0	*	0	*	7
Kelligrews	10	*	20	*	30	*
Ferryland	7	1	8	0	12	7
Bay Bulls	*	0	*	0	*	1
Trepassey	*	5	*	10	*	25
Total	17	37	28	38	42	133

* Indicates that no information was received because survey was not returned, office is vacant, or no office in a particular community.

In common with most areas, the identified numbers in need of home care were greater than for other services. The numbers certainly do not reach the statistical deficit relative to level II and III care. This is probably a reflection of the availability of nursing home care in St. John's. Similarly, the numbers suggested as requiring boarding home placement do not reflect the statistical surplus in the area. It is interesting to note that as of January 1986, there were 21 vacancies in licensed boarding homes in this area. Therefore, while people may be judged as in need by the public health nurse, they do not necessarily wish to apply for boarding home placement.

Although accurate statistics were not available, it is the consultants' understanding that a significant proportion of residents in licensed boarding homes in this region have come either from St. John's or from other parts of the province.

Eastern 1B - St. John's, Greater St. John's

The 1981 census population of this area was as follows:

Health District	0-14	15-64	65-74	75 +	Total
St. John's	18,520	56,370	6,266	2,614	83,770
Greater St. John's	14,980	31,122	1,714	296	48,112
Total	33,500	87,492	7,980	2,910	131,882

Projections to 1991 and 2001 provided for the Royal Commission for Eastern Region were broken down into health districts by the consultants. The projected future populations for the St. John's and Greater St. John's area are as follows:

Year	Total Population	Population 65 +	%65 +
1986	136,828	12,584	9.2
1991	141,775	14,278	10.2
2001	144,610	16,559	11.5

Application of the guidelines of 40 beds per 1000 population 65 and over for level II and III care and 30 beds per 1000 for level I care to the area population projections yields the following numbers:

Year	Population 65 +	Level II & III Beds @ 40/1000	Level I Beds @ 30/1000
1986	12,584	503	378
1991	14,278	571	428

According to the survey forms completed by the nursing homes, the following is a breakdown of current bed usage by levels of care:

Facility	Residents by Level			
	III	II	I	Total
Agnes Pratt	30	18	20	68
C.N.I.B.	0	0	39	39
Escasoni	189	0	2	191
Glenbrook Lodge	72	32	42	146
Hoyles Home	243	6	0	249*
Masonic Park	42	0	0	42
St. Luke's	81	29	22	132
St. Patrick's	167	47	0	214
Total	824	132	125	1,081

* From Department of Health report. Not indicated by facility on survey.

This table indicates there are 956 beds in use for level II and III and 125 beds for level I. There is therefore a surplus to the guideline of 453 beds in 1986, dropping to 385 in 1991. With the addition of 70 beds at Agnes Pratt, however, the surplus will be 465 in 1991. There is a deficit of level I beds in 1986 of 253, increasing to 303 in 1991.

Since Eastern regions 1A and 1B have been considered together, the surplus of level II and III beds is reduced to 283 in 1986 and 257 in 1991. The deficit of level I beds then becomes a surplus of 148 for the two districts, decreasing to 80 by 1991. Therefore at least 80 level I beds should be closed in the Avalon Peninsula by 1991.

For St. John's, the St. John's Home Care Program and the VON were asked to complete the community need survey forms. All Social Services offices in St. John's indicated they could not reply to the survey because they did not have the information available.

Results of the surveys completed by St. John's Home Care and the VON yielded the following numbers:

ESTIMATED NUMBERS IN NEED OF THE
FOLLOWING SERVICES

District	Nursing Home	Boarding Home	Home Care
St. John's Home Care	3	0	157
VON	7	9	10
Total	10	9	167

Waiting List Information provided by nursing homes in the area was as follows:

NUMBER ON WAITING LIST* BY LEVEL & LOCATION

Level	Facility	Hosp	Other Nsg Home	Home of Relative or Friend	Own Home/ Sr. Cit. Apt.	Board. Home	Total
III	Agnes Pratt	0	0	0	0	0	0
	Escasoni	81**	0	133****	0	50	264
	Glenbrook	45	57	93	150	18	363
	Hoyles Home***						
	Masonic Park	41**	1	10	7	0	59
	St. Luke's	78	7	80	0	4	169
	St. Patrick's	29	6	6	22	4	67
	Subtotal	274	71	322	179	76	922
II	Agnes Pratt	0	0	0	0	0	0
	Escasoni	12	0	140****	0	170	322
	Glenbrook	2	8	13	31	5	59
	Hoyles Home***						
	Masonic Park	32**	2	14	15	5	68
	St. Luke's	12	7	27	5	14	65
	St. Patrick's	22	9	20	36	20	107
	Subtotal	80	26	214	87	214	621
I	Agnes Pratt	0	0	1	4	0	5
	Escasoni	0	0	8****	0	0	0
	Glenbrook	0	10	14	141	4	169
	Hoyles Home***						
	Masonic Park	4	0	9	19	1	33
	St. Luke's	5	4	36	156	10	211
	St. Patrick's	2	0	15	60	15	92
	Subtotal	11	14	83	380	30	510
	Grand Total	365	111	619	646	320	2053

* Waiting lists do not necessarily accurately reflect those in "need" of nursing home care.
** Includes Miller Centre.
*** Same as Escasoni.
**** Includes own home/senior citizens apartment.

The following comments are offered on current resident and waiting list information provided by the St. John's nursing homes:

All homes had substantial numbers of residents from outside the St. John's area. Many of the residents were originally from areas without nursing home facilities at the time they moved to St. John's. Others chose St. John's because of family ties or religious affiliation. However the consultants were not able to assess to what extent these latter factors will continue to be important once there is better access to such facilities outside St. John's.

A significant proportion of the residents of Hoyles Home and Escasoni are under aged 65 multihandicapped individuals. In all other homes, the vast majority (virtually 100%) were over age 65.

Eastern 2A - Bay de Verde Peninsula

The 1981 census population of this area was as follows:

Health District	0 - 14	15 - 64	65 - 74	75 +	Total
Old Perlican	1959	4836	722	363	7880
Harbour Grace	2550	5530	515	220	8815
Carbonear	2670	5985	650	380	9685
Port de Grave	3401	7041	905	523	11870
Total	10580	23392	2792	1486	38250

Projections to 1991 and 2001 provided for the Royal Commission for Eastern 2 region were broken down into health districts by the consultants. The projected future populations for the Carbonear area are as follows:

Year	Total Population	Population 65 +	% 65 +
1986	38600	4754	12.3
1991	29110	5210	13.3
2001	39110	5992	15.3

Newfoundland Bed Study - 8514

The population of this area is more elderly than the province as a whole. In 1981, 11.2% of this area's population was aged 65 and over compared to a provincial average of 7.7%. Projections indicate this area will remain relatively older than the province to 2001 and beyond. This factor has been considered in assessing the needs of the area.

Assessment of Needs

Application of the guidelines of 40 beds per thousand population 65 and over for level II and III care and 30 beds per thousand population 65 and over for level I care to the area population projections yields the following numbers:

Year	Population 65 +	Level II & III Beds @ 40/1000	Level I Beds @ 30/1000
1986	4754	190	143
1991	5210	208	156

Until recently, Harbour Lodge was a provincial referral facility, the residents of which were primarily ambulatory post mentally ill patients or elderly persons with psychiatric problems. Opening of the 50 bed addition to this facility now under construction should relieve pressure for additional level II - III beds in this area.

Twelve of the 55 beds at Carbonear Interfaith are occupied by young mentally handicapped adults and 2 beds are designated for respite care. Therefore only 41 beds are actually available for level II - III care at this facility.

In addition to the beds in these 2 facilities, there are 57 beds for level II - III care at the Pentecostal Home. The total number of beds available in this area is 246 (including the 50 beds under construction at Harbour Lodge due to open in the fall of 1986) which yields a surplus to the norm of 56 beds (1986).

In contrast to most areas, there is a surplus of level I beds in this area. There are a total of 216 level I beds in the area (171 boarding home beds and 49 level I residents at the Pentecostal Home) for a surplus of 77 beds in 1986.

Newfoundland Bed Study - 8514

Results of surveys completed by public health nurses and district social services offices yielded the following numbers:

ESTIMATED NUMBERS IN NEED OF THE FOLLOWING SERVICES

District	Nursing Home		Boarding Home		Home Care	
	S. Serv.	PHN	S. Serv.	PHN	S. Serv.	PHN
Heart's Content	3	*	2	*	25	*
Harbour Grace	5	0	5	0	46	15
Old Perlican	*	6	*	1	*	4
Carbonear	*	4	*	4	*	3
Bay Roberts	4	3	6	9	5	33
Heart's Delight	*	15	*	14	*	23
Total	12	28	13	28	76	78

* Indicates that no information was received because survey was not returned, office is vacant, or no office in a particular community.

In common with most areas, the highest numbers were indicated as in need of home care. Public health nurses indicated higher numbers as requiring nursing home and boarding home placement. The numbers requiring nursing home placement suggested by public health nurses are well below the statistical deficit of 92 beds.

Waiting list information provided by nursing homes in the area was as follows:

NUMBER ON WAITING LIST* BY LEVEL & LOCATION

Level	Facility	Hosp	Other Nsg Home	Home of Relative or Friend	Own Home	Board Home	Total
III	Carbonear Interfaith	8	1	-	-	-	9
	Harbour Lodge**	X		X	X	X	150
	Pentecostal Home***						32
	Subtotal						191
II	Carbonear Interfaith****	-	-	-	-	-	-
	Harbour Lodge	-	-	-	-	-	-
	Pentecostal Home						14
	Subtotal						14

Level	Facility	Hosp	Other Nsg Home	Home of Relative or Friend	Own Home	Board Home	Total
I	Carbonear Interfaith****	-	-	-	-	-	-
	Harbour Lodge	-	-	-	-	-	-
	Pentecostal Home						7
	Subtotal						7

* Waiting lists do not necessarily accurately reflect those in "need" of nursing home care.

** This home completed questionnaire in this manner without providing numbers and locations.

*** This home responded as follows to the question concerning location of applicant: "The application we use does not reveal this information. We would find this out as we follow up at time bed is available."

**** This home accepts only level III residents.

Eastern 2B - Southwestern Avalon

The 1981 census population of this area was as follows:

Health District	0 - 14	15 - 64	65 - 74	75 +	Total
Markland	3289	6278	532	321	10420
Placentia	2979	6179	592	275	10025
Total	6268	12457	1124	596	20445

Projections to 1991 and 2001 provided for the Royal Commission for Eastern 2B were broken down into health districts by the consultants. The projected future populations for the Placentia, Markland, area are as follows:

Year	Total Population	Population 65 +	% 65 +
1986	20785	1913	9.2
1991	20965	2128	10.2
2001	20965	2447	11.7

The population of this area is slightly older than the province as a whole (8.4% age 65 and over in 1981 compared to the provincial average of 7.7%), and is projected to remain relatively older into the 21st century. This factor has been taken into account in assessing the needs of this area.

Application of the guidelines of 40 beds per thousand population 65 and over for level II and III care and 30 beds per 1000 population 65 and over for level I care to the area population projections yield the following numbers:

Year	Population 65 +	Level II, III Beds @ 40/1000	Level I Beds @ 30/1000
1986	1913	76	57
1991	2128	85	64

The 75 beds at Lions Manor are anticipated to be available exclusively for level II and III care. Therefore, in 1986, the area is approximately in balance. An additional 10 beds would be required to meet the guideline by 1991. As there are only 20 level I beds in the area, there is a current shortfall of 37 level I beds, rising to 44 by 1991.

Results of surveys completed by public health nurses and district social services offices yielded the following numbers:

ESTIMATED NUMBER IN NEED OF THE FOLLOWING SERVICES

District	Nursing Home		Boarding Home		Home Care	
	S. Serv.	PHN	S. Serv.	PHN	S. Serv.	PHN
Norman's Cove	*	15	*	15	*	25
Whitbourne	*	2	*	2	*	9
Placentia	24	13	18	2	50	7
St. Brides	*	0	*	0	*	8
Total	24	30	18	19	50	49

* Indicates that no information was received because survey was not returned, office is vacant, or no office in a particular community.

It is interesting to note that these estimates do not indicate large numbers in the community requiring placement in the new 75 bed nursing home.

The Department of Social Services commented that many individuals seeking admission to the new nursing home could be accommodated through the licensed boarding home program. However the lack of such facilities in the area undoubtedly influences the decision to request nursing home admission. The comment was also made that although many families tried very hard to keep their relatives at home, others preferred institutional placement rather than utilizing home support services.

Another comment received was that it was essential that home care services be consistently available and reliable. Apparently there has been experience in this area of services being provided and then withdrawn and this fact would obviously lead people to see institutional placement as a more reliable option.

Eastern 3A - Bonavista Peninsula

The 1981 census population of this area is as follows:

Health District	0 - 14	15 - 64	65 - 74	75 +	Total
Bonavista	2260	5265	675	400	8600
Bonavista S.	1710	3740	460	220	6130
Trinity	470	1120	180	115	1885
Total	4440	10125	1315	735	16615

Because of the uncertainty about future referral patterns after the opening of the Clarenville hospital and because of the lack of long term care facilities in the Clarenville district, we have assigned 100% of the Bonavista district and 75% of the Bonavista South and Trinity districts to Bonavista. The remaining 25% of Bonavista South and Trinity were assigned to Clarenville. The validity of this assignment should be checked in 2 - 3 years once there is some experience with the hospital in Clarenville. Based on 75% of Bonavista South and Trinity, the 1981 population of this catchment area is as follows:

District	0 - 14	15 - 64	65 - 74	75 +	Total
Bonavista (100%)	2260	5265	675	400	8600
Bonavista S. (75%)	1283	2805	345	165	4598
Trinity (75%)	353	840	135	86	1414
Total	3896	8910	1155	651	14612

Projections to 1991 and 2001 provided for the Royal Commission for "Eastern 3" Region were broken down into health districts by the consultants. Projected future populations for this district are as follows:

Year	Total Population	Population 65 +	% 65 +
1986	15050	2155	14.3
1991	15502	2504	16.2
2001	15967	2838	17.8

The total population of this catchment area is projected to continue to increase slowly for the next 15 years. However, the population over age 65 is projected to increase rapidly over this time frame. In 1981, 12.4% of this catchment population was aged 65 and over compared to the provincial average of 7.7%. By 2001, it is projected that 17.8% of the population of this area will be age 65 and over compared to a projected provincial average of 10.9%. This factor has been considered in assessing the needs of the area.

Application of the guidelines of 40 beds per thousand population, 65 and over for level II and III care and 30 beds per thousand population, 65 and over for level I care to the population of the area yield the following numbers:

Year	Population 65 +	Level II & III Beds @ 40/1000	Level I Beds @ 30/1000
1986	2155	86	65
1991	2504	100	75

There are currently 46 beds in use at Golden Heights Manor for level II and III care. Thus there is a shortage in 1986 of 40 level II - III beds according to the guideline. It should be noted however, that 40 additional beds have been approved for Golden Heights Manor.

There are currently 5 level I beds available to serve the northern portion of the peninsula and 37 beds in Musgravetown and Lethbridge which serve the southern end of the peninsula. It is suggested that 20 of these be considered as serving the Bonavista district and the remaining 17 be considered as serving the Clarenville district. Therefore there are 25 level I beds available to serve the Bonavista district. This leaves a shortfall of 40 beds in 1986 and 60 beds in 2001.

Results of surveys completed by public health nurses and district social services offices yielded the following numbers:

ESTIMATED NUMBERS IN NEED OF THE FOLLOWING SERVICES

District	Nursing Home		Boarding Home		Home Care	
	S. Serv.	PHN	S. Serv.	PHN	S. Serv.	PHN
Bonavista	2	10	0	3	8	26
Catalina	*	5	*	0	*	18
Trinity	*	*	*	*	*	*
Total	2	15	0	3	8	44

* Indicates that no information was received because survey was not returned, office is vacant, or no office in a particular community.

Representatives who attended the district meeting concerning long term care felt these estimates were very low.

Golden Heights Manor provided the following information on applicants awaiting admission to that facility:

NUMBER ON WAITING* LIST BY LEVEL & LOCATION

Level	Hospital	Other Nsg Home	Home of Relative or Friend	Own Home	Boarding Home	Total
III	4	3	19	8	2	36
II	3	0	5	9	4	21
I	0	0	1	3	0	4
Total	7	3	25	20	6	61

* Waiting lists do not necessarily accurately reflect those in "need" of nursing home care.

Representatives attending the long term care meeting felt there was a definite need for level I care and for respite services, as well as for additional nursing home beds. Survey replies from Social Services and Public Health nurses indicated a need to expand home care services, particularly to the areas outside the immediate Bonavista area.

Eastern 3B - Burin Peninsula

The 1981 census population of this area was as follows:

Health District	0 - 14	15 - 64	65 - 74	75 +	Total
Burin	4535	7975	600	260	13370
Grand Bank	2240	4555	440	305	7540
St. Lawrence	1625	2860	190	105	4780
Total	8400	15390	1230	670	25690

Projections to 1991 and 2001 provided for the Royal Commission for Eastern 3 region were broken down into health districts by the consultants. The projected future populations for the Burin Peninsula are as follows:

Year	Total Population	Population 65 +	% 65 +
1986	26395	2237	8.5
1991	27100	2574	9.5
2001	27900	2955	10.6

In 1981 this district was slightly younger than the provincial average - 7.4% aged 65 and over compared to the provincial average of 7.7%. The area is projected to remain slightly younger than the provincial average by 2001.

Application of the guidelines of 40 beds per thousand population 65 and over for level II and III care and 30 beds per thousand for level I care to the population projections yields the following numbers:

Year	Population 65 +	Level II & III Beds @ 40/1000	Level I Beds @ 30/1000
1986	2237	89	67
1991	2574	103	77

Currently there are 68 beds at Blue Crest Interfaith Home occupied by level II and III residents for a shortfall of 21 beds below the guideline. This deficit will rise to 35 beds by 1991. There are 26 level I residents in Blue Crest, leaving a deficit of 41 beds at present and rising to 51 by 1991. However an additional 15 level II and III beds will become available when the new hospital in Salt Pond opens.

Surveys completed by public health nurses and district social services offices provided the following information:

ESTIMATED NUMBERS IN NEED OF THE
FOLLOWING SERVICES

District	Nursing Home		Boarding Home		Home Care	
	S. Serv.	PHN	S. Serv.	PHN	S. Serv.	PHN
Bay L'Argent	3	*	5	*	27	*
Marystown	9	20	2	20	20	60
Grand Bank	*	6	*	3	*	33
Burin	*	40	*	20	*	20
St. Bernard's	*	3	*	6	*	30
St. Lawrence	*	0	*	0	*	9
Total	12	69	7	49	47	152

* Indicates that no information was received because survey was not returned, office is vacant, or no office in a particular community.

In common with most areas, the numbers identified by Social Services offices are smaller in all categories than the numbers identified by public health nurses.

The waiting list survey completed by Blue Crest Interfaith Home yielded the following information:

NUMBER ON WAITING* LIST BY LEVEL & LOCATION

Level	Hospital	Other Nsg Home	Home of Relative or Friend	Own Home	Boarding Home	Total
III	11	2	8	11	7	39
II	0	0	4	18	2	24
I	0	0	5	9	2	16
Total	11	2	17	38	11	79

* Waiting lists do not necessarily accurately reflect those in "need" of nursing home care.

Unlike many areas, the numbers provided by public health nurses as requiring nursing home care were greater than the numbers of level II and III residents living in the community on the waiting list of the nursing home (69 compared to 31).

In assessing needs in this area, the traditional referral patterns should be understood. Grand Bank was the centre of commerce for the entire south coast of the province until roads were built connecting Burgeo and Harbour Breton to other communities. We understand from people in these communities that construction of the roads has significantly altered the patterns of referral on the south coast. In the future, provision of long term care services in Burgeo and Harbour Breton - St. Albans areas may further change new referrals to Grand Bank for long term care. Therefore, except for people from the south coast who choose Grand Bank over facilities in Burgeo or the Harbour Breton - St. Albans district, in future it is anticipated that the catchment area of long term care facilities in the Burin Peninsula will be confined to the Burin Peninsula.

Eastern 3C - Clarenville, Come by Chance

As discussed in the Bonavista section of this report, the districts of Bonavista South and Trinity appear to have a natural split between Bonavista and Clarenville. For planning purposes at this time we have allocated 75% of this population to Bonavista and 25% to Clarenville. The total 1981 census population of the districts included was as follows:

District	0 - 14	15 - 64	65 - 74	75 +	Total
Bonavista S.	1710	3740	460	220	6130
Trinity	470	1120	180	115	1885
Come by Chance	6045	11445	1110	610	19210
Total	8225	16305	1750	2945	27225

Assigning 25% of the Trinity and Bonavista South populations to Clarenville yields the following figures for the population of the Clarenville catchment area:

District	0 - 14	15 - 64	65 - 74	75 +	Total
Bonavista S. (25%)	428	935	115	55	1533
Trinity (25%)	118	280	45	29	472
Come by Chance	6045	11445	1110	610	19210
Total	6591	12660	1270	694	21215

Projections to 1991 and 2001 provided by the Royal Commission were broken down into health districts by the consultants. The projected future populations for this catchment area are as follows:

Year	Total Population	Population 65 +	% 65 +
1986	21851	2298	10.5
1991	22507	2777	12.3
2001	23182	3182	13.7

The population of this district is relatively older than the provincial average (9.3% compared to the provincial average of 7.7% in 1981) and is projected to continue to be older than the provincial average to 2001. This factor has been taken into account in assessing needs.

Application of the guidelines of 40 beds per 1000 population aged 65 and over for level II and III care and 30 beds per 1000 population aged 65 and over for level I care to the area population projections yields the following numbers:

Year	Population 65 +	Level II & III Beds @ 40/1000	Level I Beds @ 30/1000
1986	2298	92	69
1991	2777	111	83

Since there are no level II and III beds in the area, there is obviously a current shortfall of 92 beds. The number of level I beds is in balance according to the guideline.

Since there is no nursing home in the district, no waiting list information is available.

Results of surveys completed by public health nurses and district social services offices yielded the following numbers.

ESTIMATED NUMBERS IN NEED OF THE FOLLOWING SERVICES

District	Nursing Home		Boarding Home		Home Care	
	S. Serv.	PHN	S. Serv.	PHN	S. Serv.	PHN
Clarenville	15	15	18	57	49	84
Come by Chance	*	200	*	100	*	200
Arnold's Cove	10	*	8	*	20	*
Total	25	215	26	157	69	284

* Indicates that no information was received because survey was not returned, office is vacant, or no office in a particular community.

Discussion & Recommendations

Eastern 1A - Avalon

The main characteristic of this area is that it contains one hospital (Dr. Walter Templeman) and no other health facilities except for a very large number of licensed boarding home beds. For the people of this area, the primary source of acute and nursing home care is St. John's. This pattern is expected to continue, especially in view of existing capacities in St. John's. To some extent, there is an offsetting trend in which residents of St. John's have sought boarding home care outside St. John's. Following are the consultants' recommendations for this area:

Home Care/Home Support

Development of comprehensive home care/home support services should be considered a priority in this area. Funds now committed to acute care should be reallocated to the provision of home care services as soon as the change in role and capacity recommended below for the Dr. W. Templeman Hospital occurs.

The Dr. Walter Templeman Hospital in Bell Island is a 40 bed acute care hospital operating at an occupancy rate of approximately 40%. Many of its patient days are in fact accounted for by long term care patients. As the only health care facility on Bell Island, it should become a multipurpose health centre providing holding beds for acute care, level II and III nursing care, and be closely involved in provision of home care and level I services. This role change should be possible within the following capacity:

Acute care	6
Level II - III	12
Respite	2

Although there is a surplus of level I, II and III beds in the Avalon and St. John's district, the isolation of Bell Island merits special consideration. Therefore in the medium to long term development of a six bed level I facility should be considered.

Other Facilities

According to the planning guidelines, there is a substantial surplus of level I beds on the Avalon Peninsula even considering the lack of boarding homes in St. John's. Also, there are vacancies in the Licensed Boarding Home Program. Additional factors as follows, however, require further consideration.

Twenty-nine percent of the licensed boarding home residents are mentally handicapped and an additional 11% are mentally ill. These residents have come from all parts of the province. Many have been in institutional or boarding home care for a number of years and no longer have strong ties with their original community. Therefore considering all the beds occupied by these residents as part of the inventory of beds available to residents of the Avalon Peninsula may be inappropriate.

A detailed study should be undertaken to determine the need for level I facilities in the Avalon Peninsula including St. John's. Until the results of this study are available, no additional licensed boarding home beds should be approved for the Avalon Peninsula. If existing homes close or reduce capacity, those beds should not be replaced elsewhere unless they are required according to the detailed study.

Eastern 1B - St. John's, Greater St. John's

Home Care/Home Support

Although home care services in St. John's are more comprehensive than in most other areas of the province, there is still potential to expand these services and improve their utilization, particularly as tradeoffs to use of acute care beds. Optimal utilization of available home care/home support services and expansion of these services to meet the needs should be regarded as a high priority.

Hospitals

As previously discussed, the allocation of acute care beds among hospitals in St. John's is the responsibility of the St. John's Hospital Council. Therefore this issue will not be addressed here. However, the consultants consider the 1185 beds recommended by the Royal Commission as more than adequate to meet the acute care needs to 2001.

Rehabilitation

As indicated in the needs assessment section, there is a need to expand rehabilitation services in the region. Although 30 beds are in operation at the Miller Centre, some are occupied by non rehabilitation patients. As soon as possible, all 30 beds should become available for rehabilitation patients. The need to expand beyond 30 will depend to some degree on the impact of facilities recommended in Corner Brook and Gander and also on the extent to which ambulatory care programs can be used for rehabilitation. The capacity of this unit should therefore remain at 30 but the need to expand should be reviewed again in 3 years.

Other Facilities

According to the guidelines, there is a substantial surplus of nursing home beds in St. John's. This holds true even when the population of district Eastern 1A is added to the St. John's catchment area. However, many residents of St. John's nursing homes have come to St. John's from other areas of the province for a variety of reasons including family ties, lack of appropriate services close to home, religious affiliation, etc. The extent to which these factors justify additional beds in St. John's is not known, as is the extent to which this will change in future when long term care services are available throughout Newfoundland. A mechanism should be established for assessing the number of persons from other areas of the province who will relocate to St. John's to obtain long term care services in the future in order that planning for the appropriate facilities can be done.

Without adequate assessment and placement services and the information base generated by such services, the consultants were unable to determine the number of beds that should be provided in St. John's. There is clearly substantial duplication of waiting list numbers and there is no coordinated placement service. Therefore, the following recommendations are made for St. John's:

1. An assessment and placement service with an appropriate information system such as is being developed at the Miller Centre should be implemented as soon as possible. All nursing home waiting lists from St. John's nursing homes should be referred to this service for review prior to placement.

2. There does not appear to be a need to construct additional nursing home beds in St. John's before 1991. During the next three years, improved assessment services should permit better planning for long term care services including those provided on an ambulatory basis. Planning in St. John's should include development of a coordinated plan for day care and other outreach services.

3. At least two respite beds should be designated in each nursing home in St. John's. Clients of the St. John's Home Care Program should have priority access to a portion of these beds.

Eastern 2A - The Bay de Verde Peninsula

Home Care/Home Support

Comprehensive Home Care and Home Support services should be developed as a priority throughout this district to serve the needs of both acute and long term care patients.

Carbonear

The Carbonear General Hospital has potential to expand to a total capacity of 124 beds but in fact has operated at 100 beds or less since opening. At the time of the consultants' visit, 86 beds were staffed and in operation.

The 32 bed medical unit at this hospital has operated at a capacity of 95% or more for the past five years. Some of this high occupancy is due to beds being blocked by long term patients and to lack of psychiatric services. In order to determine whether there were other factors creating this occupancy, the hospital requested HMRI to provide length of stay comparisons for hospitals with similar caseloads elsewhere in Canada. In all but one of the ten medical diagnoses selected, Carbonear had a shorter length of stay (in several cases substantial) than the comparison group.

The 25 bed surgical unit is currently operating at 19 beds. There are an additional 9 beds assigned to gynecology for a total of 34 surgical beds of which 28 were staffed and in operation at the time of the consultants' visit. Based on the reported 34 beds, surgical occupancy rates have been running at 75 - 80% for the past few years. However, based on 28 beds in operation, the occupancy rate in 1984/85 was 93%. The HMRI comparisons referenced above suggest there may be some potential to reduce average length of stay for certain surgical procedures at Carbonear.

It should be noted that average occupancy rates in excess of 90% are not considered acceptable in medical and surgical beds due to the need to provide for emergency admissions.

Obstetrical occupancy rates have been running consistently between 70 - 75% for the past five years. This is a relatively high occupancy rate for an obstetrical unit of this size but within acceptable limits. Given the fact that obstetrical days are substantially higher than newborn days, there may be potential to reduce obstetrical lengths of stay, particularly for cesarean sections. Such reductions would not however, affect the bed numbers in the short run, but reductions should be considered in future.

The 12 bed pediatric unit is currently operating at 6 beds. There is no pediatrician on staff at present, although recruitment of one is anticipated in future. Pediatric workload is expected to remain relatively stable in the future, although recruitment of a pediatrician may in fact reduce inpatient utilization (based on experience elsewhere). Design of the pediatric unit is suitable for conversion to adult use.

The 15 bed psychiatric unit is not open at present. The need to open these psychiatric beds should be considered as part of the overall provincial plan for development of mental health services.

The phasing out of Old Perlican Hospital as an acute care facility recommended later in this section will have a minor effect on the bed requirements at Carbonear General Hospital. If the 1984/85 patient days at Old Perlican were all reallocated to Carbonear, an additional 15 beds at 85% occupancy would be required. In reality, however, at least 2/3 of the patient load at Old Perlican is considered to be long stay. Therefore only five additional acute care beds would be required in Carbonear when Old Perlican closes. Fewer beds may in fact be required to open if reductions in length of stay in surgery can be achieved.

An additional 50 long term beds will be opened at Harbour Lodge in the near future. These beds are to be available to the Bay de Verde area, and should relieve the pressure on acute care beds created by long term patients in Carbonear and Old Perlican.

In order to maintain more acceptable occupancy levels, it is recommended that the Carbonear General Hospital restore its operating capacity to 100 beds. The distribution between services should be the prerogative of the hospital, taking into account the previous comments. If the overall plan for mental health services identifies a need to open the psychiatric unit, this unit should become operational at that time. When agreement is reached to phase out Old Perlican for acute care, the need to open a further 5 - 6 beds at Carbonear should be reviewed.

The extent to which Harbour Lodge will remain a referral centre for the entire province should decline as facilities are provided in the rest of the province. Therefore over time it should become available to this area. It is intended that the 50 beds currently under construction will give priority access to residents of the Bay de Verde Peninsula. Therefore no changes in bed numbers are recommended for this facility at this time.

Carbonear Interfaith Home has specialized in heavy care residents and in young mentally handicapped residents. It operates a very active day care program which plays an important community role. Additional staff may be required to permit full development of services. Expansion of physiotherapy and occupational therapy staff is required.

In view of the expansion underway at Harbour Lodge, there does not appear to be a need to expand the capacity of Carbonear Interfaith at this time. The situation should be reviewed in 1990/91, however, after decisions concerning Old Perlican, Pentecostal Home and the role of Harbour Lodge are known.

Old Perlican

Old Perlican Hospital reports 23 beds as being in operation but during the consultants' visit, only 15 were actually operational. The consultants were advised that 65% of the patient days were attributable to long stay patients.

This hospital is no longer suitable for provision of acute care and is not appropriate to provide long term care. It should be replaced in the medium term. Since Carbonear General Hospital has the capacity to meet all the acute care bed requirements for this district, only ambulatory care facilities should be required at Old Perlican. Since the expansion and projected changing role of Harbour Lodge will meet the needs for level II and III care for the district, no long term care beds should be required at Old Perlican.

Clarke's Beach

Because of overcrowding at the Pentecostal Home, the capacity of this facility should be reduced to a maximum of 95 as beds become vacant. Improved programming for residents is required and outreach services such as day care should be considered. New admissions should be restricted to level II and III over time, and renovations to accommodate this change in role should be undertaken. Such renovations may require a reduction in capacity to approximately 75 beds.

Other Facilities

There is a surplus to the norm of licensed boarding home beds in this area. As of January 1986 there were 17 vacant licensed boarding home beds in this district. Therefore no additional beds are recommended at this time.

Eastern 2B - Southwestern Avalon

Home Care/Home Support

There is a need to develop comprehensive home care/home support services throughout this district.

The Placentia Cottage Hospital rated at 35 beds, in fact operates at 32 beds. However, of these 32 beds, 7 are located in a crib room and 7 are allocated to obstetrics. Both these services operate at very low occupancy rates. There are a number of long stay patients in the hospital but these should be transferred to Lions Manor when it opens.

This building requires replacement. Ambulatory care facilities are very limited and the hospital is poorly located.

Ideally, replacement facilities with a reduced inpatient capacity and improved ambulatory care facilities would have been constructed as part of a multipurpose centre to include long term care. However, since Lions Manor is already constructed and was not designed to incorporate acute care facilities, this option is not available. Planning for a multi-purpose centre, which among other things, should contain a maximum of 10 acute care beds in multi-purpose rooms, should begin in the near future.

Lions Manor is a new 75 bed facility due to open in the spring of 1986. It is recommended that only 50 beds be opened in 1986 and that funds originally budgeted for the operation of the other 25 beds be allocated to development of community home care/home support services. In addition to the two beds designated for respite, an additional three beds should be held for emergency placements and convalescent care.

Other Facilities

Although there is a deficit of level I beds in this district, this deficit is more than accommodated by the surplus of level I facilities on the Avalon Peninsula. Until a detailed study is undertaken to determine the need for level I beds in the entire Avalon Peninsula, no additional licensed boarding home beds should be provided in this area. If and when additional level I facilities are required in this district, they should operate in close cooperation with Lions Manor.

Eastern 3A - Bonavista Peninsula

Home Care/Home Support

Comprehensive home care/home support services should be developed as a priority throughout this district.

Bonavista Cottage Hospital is a new 25 bed facility which operates at a capacity of 15 acute care beds. There are 10 beds designated for long term care which remain unopened. The hospital staff expressed major frustrations with chronic blocking of acute care beds by long term patients and with the need to transfer acutely ill patients to St. John's because of lack of available beds locally.

The occupancy rate of this facility has been gradually increasing over the past 4 years and was 75% in 1984/85. Given that 3 of the beds are pediatric, this is a high occupancy for this size of hospital. Since a major portion of the patient days are for long term patients, this pressure should be somewhat relieved when the additional 40 beds approved for Golden Heights Manor become operational. Also the effect of Clarenville hospital will not be felt for some time. Therefore, no change is recommended in the 15 bed capacity of Bonavista Hospital.

Golden Heights Manor recently received approval to construct 40 additional beds. While these beds will relieve a substantial amount of the pressure for long term care beds in the area, there will still be a shortfall of 4 beds according to the norm by 1991. Therefore the need to open additional beds either in the hospital or Golden Heights Manor should be reviewed further after the 40 new beds have become operational. Two of these new beds should be designated for respite, convalescent care and emergency placement. Construction should also provide appropriate facilities for physiotherapy and occupational therapy. Any additional staff should be shared with the hospital.

Other Facilities

There is a deficit to the norm of 40 level I beds, rising to a deficit of 60 by 1991. There appears to be a demand for this level of care in the area. It is therefore recommended that up to 20 personal care (level I) beds be provided in the Bonavista - Catalina area. If and when these beds become well accepted, an additional 20 beds should be provided in the Summerville - Plate Cove area. These beds should be closely related to the operation of Golden Heights Manor.

Eastern 3B - Burin Peninsula

Home Care/Home Support

The Blue Crest Interfaith Home provides home care/home support services to a limited area in the immediate vicinity of Grand Bank. This program has not gained wide acceptance. However health care providers throughout the district believed that home care would be accepted when it is consistently available throughout the district. Therefore development of home care/home support services should be considered a priority in the area.

Burin

Burin Cottage Hospital is due to be closed when the new hospital in Salt Pond opens. The consultants endorse the decision to cease utilizing the existing hospital for either acute or long term patient care.

Salt Pond

A new hospital is currently under construction in Salt Pond and will contain 60 acute and 15 long term care beds. Program development for the 15 long term care beds should be closely related to the resources of the Blue Crest Interfaith Home in Grand Bank.

St. Lawrence

The U.S. Memorial Hospital is a 22 bed hospital which operates at a capacity below 40%. When the new hospital opens in Salt Pond, it should accommodate all the inpatient acute care needs now being accommodated in this hospital. There does not appear to be any need to continue to provide inpatient care for acute or long term care at this location when the new hospital in Salt Pond opens. Ambulatory clinic facilities should, however, be maintained.

Grand Bank

Grand Bank Cottage Hospital is due to close as an inpatient facility when the new hospital opens in Salt Pond. The consultants endorse this decision as the existing hospital is unsuitable for continued use as an inpatient facility for acute or long term care, and would require major upgrading to provide appropriate ambulatory care facilities.

There will continue to be a need for ambulatory care and emergency facilities to serve this area. On occasion it may be necessary to hold patients for observation prior to discharge or transfer. Therefore 2 - 4 holding beds should be considered for the area. It is recommended that a new clinic facility with 2 - 4 holding beds be constructed to replace the existing hospital. If the site is suitable, a location close to the Blue Crest Interfaith Home should be considered in order to allow for maximum sharing of services. However, careful planning will be required to ensure proper access for emergency vehicles, adequacy of parking, etc.

Blue Crest Interfaith Home currently has 68 beds for level II and III residents and an additional 18 level I beds could be made suitable for level II and III care for a total of 86. The 15 beds at Salt Pond will provide a total for the area of 101 which is sufficient to meet the 1991 need. The need for additional beds after 1991 should be considered further once assessment and placement services are in place.

For several years this home has served the entire south coast of Newfoundland because of the lack of facilities in those areas. This report has recommended provision of long term beds both in Burgeo and in the Harbour Breton - St. Albans district. In the future, therefore, Grand Bank should receive fewer referrals from those areas. Also, this institution currently serves the entire Burin Peninsula up to the Swift Current area. This pattern may change when the services recommended for Clarenville are available.

Other Facilities

There is a current shortfall of 41 level I beds in the district which will rise to 69 in 1991 if Blue Crest Interfaith converts 18 level I beds to level II and III as recommended above. Therefore planning should begin for provision of up to 40 beds throughout the district over the next 5 years. These 40 beds include the 6 beds already under consideration for Marystown. At least 6 beds should be located in the St. Lawrence area.

Eastern 3C - Clarenville, Come by Chance

Home Care/Home Support

Comprehensive home care and home support services are required throughout this district.

Clarenville

The Dr. G. B. Cross Hospital is a new 75 bed hospital due to open in 1986 which will provide 60 acute and 15 long term care beds. Because this is a new facility, there is no experience upon which to draw for utilization. The extent to which the presence of this hospital affects referral of patients to St. John's should be evaluated in 3 to 4 years time for purposes of planning bed requirements in St. John's.

Level II & III Facilities

According to the norm, there is a need for level II-III beds in this area. The consultants have been advised that 15 long term care beds are planned for the new Dr. G. B. Cross Hospital. These beds should be opened during fiscal 1986/87 and resources should be committed to the development of comprehensive home care/home support services. The impact of these services on the need for long term care beds should be evaluated before building a new facility in this area.

It is anticipated that as a result of home care/home support services, the number of beds required will be fewer than indicated by application of the norm. However it seems likely that a facility of up to 50 beds in addition to the 15 beds at the Dr. G. B. Cross Hospital, will be required. Planning should begin for this before 1990.

Come By Chance

Come By Chance Hospital is a 24 bed hospital which operates at an occupancy rate of approximately 60% with the majority of patient days attributable to long stay patients. This hospital is due to close as an inpatient facility when the new hospital opens in Clarenville. This decision is entirely appropriate as the existing facilities are unsuitable for continued use for acute inpatient care or for long term care. Ambulatory care facilities will continue to be required in this area.

Other Facilities

There does not appear to be a need for additional level I facilities in this district at this time. The situation should, however, be reassessed in 1991 at the latest.

Eastern Region

SUMMARY OF PRESENT CAPACITY* AND RECOMMENDED CAPACITY

District/Facility	Total Capacity (1985/86)	Recommended Capacity				
		Acute (2001)	Rehab (1991)	Level II & III (1991)	Level I (1991)	Respite** (1991)
Eastern 1A						
Dr. W. Templeman	40	6		12		2
Personal Care Beds	529				529	
Subtotal		6		12	529	2
Eastern 1B						
St. Clares Mercy	323					
Health Sciences Cntr	342					
Grace General	292					
Dr. C.A. Janeway Child Health Cntr	193					
Subtotal	1150	1185				
Miller Centre	204		50***	154****		
Agnes Pratt Home	66(+70)			114	20	2
Escasoni	191			187	2	2
Glenbrook Lodge	146			102	42	2
Hoyles Home	249			247		2
Masonic Park	42			40		2
St. Luke's	132			108	22	2
St. Patrick's Mercy Home	214			212		2
Personal Care Beds						
Subtotal			50	1164	86	14
Total (Eastern 1)		1191	50	1176	615	16

District/Facility	Total Capacity (1985/86)	Recommended Capacity				
		Acute (2001)	Rehab (1991)	Level II & III (1991)	Level I (1991)	Respite** (1991)
Eastern 2A						
Carbonear Gen.	100	100				
Carbonear Interfaith	55			53		2
Harbour Lodge	98			146		2
Old Perlican Hospital	15	0		0		
Pentecostal Home	102			46	49	
Personal Care Beds	171				171	
Subtotal		100		245	220	4
Eastern 2B						
Placentia Hospital	32	10				
Lions Manor	75			70*****		5
Personal Care Beds	20				20	
Subtotal		10		70*****	20	5
Total (Eastern 2)		110		315	240	9
Eastern 3A						
Bonavista Hosp.	15	15				
Golden Hts Manor	47			85		2
Personal Care Beds	4				24	
Subtotal		15		85	24	2
Eastern 3B						
New Hospital	0	60		15		
Burin Cott Hospital	31	0				
St. Lawrence Hosp	22	0				
Grand Bank Hospital	31	2-4				
Blue Crest Interfth	94			84	8	2
Personal Care Beds					40	
Subtotal		62-64		99	48	2

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District/Facility	Total Capacity (1985/86)	Recommended Capacity				
		Acute (2001)	Rehab (1991)	Level II & III (1991)	Level I (1991)	Respite** (1991)
Eastern 3C						
Dr. G. B. Cross Hosp.	0	60		15		
Come by Chance Hosp.	24	0				
New Nsg Home	0			50******		2
Personal Care Beds	89				89	
Subtotal		60		65	89	2
Total (Eastern 3)		137-139		190	161	6
Grand Total (Recom'd Capacity)		1438-1440	50	1681	1016	31
(Present Total Capacity)		(1396)	(50)	(1391)	(962)	(2)

* Present capacity based on beds open at time of consultants' visit or on information received since visit.

** Includes convalescent and emergency use.

*** Includes 20 beds for special rehabilitation and 30 beds for general rehabilitation.

**** Includes convalescent, veterans, old age psychiatry.

***** Only 45 of these should be opened in the short run in order to reallocate resources to development of home care and home support services.

****** Number of beds required will depend on success of home care services. This number should be reassessed before construction proceeds.

Note: There are approximately 450 beds at the Waterford Hospital for acute and long term psychiatric care. These are not included in this table.

Appendices

Discussion Paper - Obstetrics

Throughout North America birth rates have been declining over the past years. This trend has resulted in a declining number of births and hence declining obstetrical patient days. For many reasons, the practice of obstetrics has become more specialized with the result that an increasing percentage of deliveries occur in regional centres where specialty services are available.

Tables 0-1(a) and 0-1(b) provide information on newborn patient days for 1976/77, 1980/81 and 1983/84 for hospitals divided into two size groups. Note that total days declined from 61,811 in 1976/77 to 48,143 in 1983/84 and that the percentage occurring in small hospitals declined from 8.4% to 4.4% of the total.

Table 0 - 2 provides a comparison by hospital in 1983/84 of obstetrical occupancy rates based on reported obstetrical days compared to newborn days. There are significant discrepancies in the two figures which will be partially explained by the following factors:

1. Antenatal admission of high risk patients;
2. Antenatal admission of normal patients living in outlying areas;
3. Use of obstetrical beds for non-obstetrical patients but reporting these days as obstetrical.

Table 0 - 3 provides information on obstetrical utilization rates by the patients' residence for 1971, 1982/83 and 1983/84. Note that the overall separation rate has declined from 32.8 per thousand to 23.1 per thousand but average length of stay actually increased from 5.7 to 5.9 days.

Average length of stay for Newfoundland obstetrical cases is high compared to Canada as a whole. Although geography may provide a partial explanation, it certainly does not provide a total answer since the St. John's rate is one of the highest in the province while the rate for Western region residents is the lowest. In fact, with the exception of Labrador, the highest lengths of stay occur in the regions which receive almost 100% of their obstetrical care in St. John's (i.e. St. John's and Eastern III regions).

There is certainly room for current and future reduction in obstetrical beds. Not only are existing beds underutilized throughout the province, but the total number of births in the province has dropped and is expected to continue to decline although at a slower pace. Additionally, shorter lengths of stay should be encouraged. It is well known that excess bed capacity encourages obstetrical lengths of stay to remain unnecessarily high.

Another factor requiring consideration relative to bed allocations is the type of obstetrical practices and unit configurations that have been and will be in place throughout the province. In larger hospitals, policy has been to provide inpatient units for postpartum and nursery separate from other nursing units in order to minimize infection. In small hospitals such separation as was reasonable was provided. In such hospitals also the labour/delivery/recovery suite was often separate from the postpartum and nursery area and staffed separately. Sometimes the labour/delivery/recovery suite adjoined the OR, a convenient arrangement for shared staffing and for rapid transfer of patients for emergency Caesarean sections.

Modern obstetrical care is changing across Canada. Although this trend seems to have had little impact in Newfoundland yet, it will undoubtedly have a significant impact during the next few years.

Consumers, physicians and nurses are increasingly becoming aware of the benefits of family-centered obstetrical care. Part of this philosophy is the "normalization" of childbirth and the creation of an environment which is as non-medical and non-technical as possible. Increasingly labour and delivery occur in one domestically decorated but appropriately equipped "birthing room". Where possible, the family remains in the "birthing room" for the first few hours postpartum. Nursing care is more and more being done by "combined care" in which mother and infant are cared for by one nurse. Where design and workload permit labour/delivery/recovery, postpartum and nursery are staffed as one nursing unit for provision of better continuity of care.

Another problem facing Newfoundland is geography. Because of distances to major centres a number of small hospitals will undoubtedly be required to continue to perform some deliveries for years to come, although the number of these is expected to continue to decline.

Another factor that affects obstetrical referral patterns is availability of a surgeon. Traditionally, it has been considered necessary to be capable of performing emergency Caesarean sections if an obstetrical service was to be offered. With improved antenatal screening and the reduction in availability of general surgeons in small hospitals, this requirement has become less and less practical.

The pattern of obstetrical practice is often dependent on the interests and skills of general practitioners in small communities. Future trends in this area are difficult to predict except to say that there is a trend nationwide for general practitioners to give up obstetrical practice. There is clearly a variation in practice throughout rural Newfoundland with some general practitioners desiring to continue practicing obstetrics, with others not so desiring.

Because of isolation, many small hospitals must be capable of performing deliveries. Therefore, from a planning point of view, facilities must be provided even though they will not be "economic". Modest obstetrical facilities should, therefore, continue to be available in most acute care hospitals now doing obstetrics with the exception of those within reasonable traveling time to a regional centre.

If, as predicted, more centralization occurs and increasing percentages of deliveries are performed in regional centres, such centres should provide adequate hostel facilities in order to avoid unnecessary antenatal hospitalization. Also, adequate follow-up services should be available in all communities in order to avoid unnecessarily lengthy postpartum hospital stays. If both these services are in place, bed requirements in regional centres should continue to decrease.

Future numbers of births are difficult to predict. However, based on the fertility rate of 1.93 used by the Newfoundland Statistics Agency there may be a slight increase in births over the next decade (from a current level of about 9,000 to about 9,400 in the early 1990's) but after 1996 the number of births is expected to decline again. If there are 9,400 deliveries with an average length of stay of 4.5 days, the number of obstetrical beds used at 65% occupancy would be 178 for the province as compared to the present number of 296 for a surplus of 118.

Reductions in obstetrical beds have been recommended for various regions. However there should be potential to reduce requirements for obstetrical beds further once hostel facilities and improved home care services are in place to encourage shorter lengths of stay.

Recommendations

1. Despite trends toward centralization, some deliveries will continue to be performed in small hospitals for the foreseeable future. When replacement acute care facilities are planned for cottage hospitals, the need to maintain the capability of performing deliveries should be considered. It would be preferable however, if the space provided could be used for a variety of purposes.

2. Obstetrics should be targetted as a specialty in which average lengths of stay can be substantially reduced throughout Newfoundland. Such reductions should create the potential to reduce beds beyond the levels recommended in this report.

3. An overall guideline has not been recommended for obstetrics. These beds are part of the 3.5 - 4.0 beds per thousand guideline used for acute care.

Table 0-1(a)

Newborn Patient Days
Hospitals 35 Beds & Under
1976/77, 1980/81, 1983/84

Hospital	1976/77	1980/81	1983/84
Churchill Falls	122	16	0
Makkovik	41	4	0
Hopedale	22	3	20
Nain	80	48	58
Forteau	52	0	0
Cartwright	14	10	8
Flowers Cove	80	1	3
Roddickton	81	9	0
Port Saunders	27	8	3
Burgeo	238	209	103
Bonne Bay	309	161	79
Buchans	119	38	0
Springdale	555	561	403
Brookfield	569	278	246
Fogo	144	194	113
Harbour Breton	308	138	96
St. Lawrence	358	152	112
Grand Bank	719	272	187
Come By Chance	207	90	80
Burin	496	532	343
Bonavista	211	57	11
Placentia	387	214	258
Old Perlican	43	35	0
Mary's Harbour	26	0	0
Subtotal, Hospitals ≤ 35 beds	5,208	3,030	2,123

Table O-1(b)

Newborn Patient Days
Hospitals Over 35 Beds
1976/77, 1980/81, 1983/84

Hospital	1976/77	1980/81	1983/84
Melville	92	833	1,447
Jackman	2,474	1,682	861
Northwest River	447	182	5
Curtis	2,979	2,836	2,260
Roddick	2,486	1,868	2,001
Western	6,306	5,668	4,783
Channel	1,206	855	411
Boylen	655	756	557
Paton	3,661	2,657	2,734
Central Nfld	4,348	3,985	3,983
Botwood	390	140	54
Notre Dame Bay	576	617	671
Carbonear	2,168	2,499	2,526
Templeman	273	134	0
Grace	17,074	13,130	12,576
St. Clares	10,588	10,960	11,151
Subtotal, Hospitals >35 beds	56,603	48,802	46,120
Total, Newborn Patient Days	61,811	51,832	48,243
Small Hospitals as % of Total	8.4%	5.8%	4.4%

Source: Department of Health, Newfoundland and Labrador

Table O-2

Obstetrical Beds
Patient Days & Occupancy Rates
by Region & Hospital, Newfoundland
1983/84

Region	Hospital	Obs Pat. Days	Newborn Pat Days	Obs Beds	Percentage Occup. Obs Days	Percentage Occup. N.B. Days
Labrador	Jackman	1,104	861	11	27.5	21.4
	Melville	2,418	1,147	10	66.2	39.6
	Makkovik	0	0	1	-	-
	Nain	56	58	2	7.7	7.9
	Forteau	22	0	1	6.0	-
	Cartwright	15	8	2	2.1	1.1
	Subtotal	3,615	2,374	27		
Northern	Roddickton	22	0	1	6.0	-
	Curtis	3,916	2,260	20	53.6	31.0
	Port Saunders	58	3	2	7.9	-
	Subtotal	3,996	2,263	23		
Western	Roddick	3,250	2,001	14	63.6	39.2
	Western	7,807	4,783	29	73.8	45.2
	Channel	594	411	8	20.3	14.1
	Subtotal	11,651	7,195	51		
Central	Boylen	911	557	4	62.4	38.2
	Paton	3,843	2,734	23	45.8	32.6
	Central Nfld	5,616	3,983	20	76.9	54.6
	Springdale	-	403	2	-	55.2
	Brookfield	-	246	6	-	11.2
	Harbour Breton	157	96	5	8.6	5.3
	Notre Dame Bay	932	671	6	42.6	30.6
	Subtotal	11,459	8,690	66		

Table O-2 (cont'd)

Obstetrical Beds
Patient Days & Occupancy Rates
by Region & Hospital, Newfoundland
1983/84

Region	Hospital	Obs Pat Days	Newborn Pat Days	Obs Beds	Percentage Occup.	
					Obs Days	N.B. Days
Eastern III	St. Lawrence	-	112	5	-	6.1
	Grand Bank	-	187	4	-	12.8
	Burin	-	343	6	-	15.7
	Subtotal	-	642	15		
Eastern II	Carbonear	4,236	2,526	16	72.5	43.3
Eastern I	St. John's					
	Grace	17,266	12,576	58	81.6	59.4
	St. Clares	16,370	11,151	55	81.5	55.5
	Subtotal	33,636	23,727	113		
	Grand Total	68,593	47,417	311		

Source: Annual Return of Hospitals

Note: Only hospitals reporting obstetrical beds are included: A very small additional number of deliveries occur in other hospitals.

Table 0-3

Obstetrical* Utilization Rates by Region

Region	1971		1982/83		1983/84	
	Seps/1000	Av Stay	Seps/1000	Av Stay	Seps/1000	Av Stay
St. John's	28.8	6.0	23.2	5.8	23.0	5.9
Eastern II	29.9	5.7	22.2	5.8	23.9	5.8
Eastern III	37.5	4.9	23.4	6.2	24.4	6.5
Subtotal, Eastern	30.9	5.7	22.9	5.9	23.6	6.0
Central	33.8	5.6	22.7	5.0	22.4	5.7
Western	33.3	5.8	23.9	5.1	21.6	5.3
Northern	36.2	7.1	28.1	5.7	27.3	5.8
Labrador	43.7	5.9	29.2	5.2	23.4	6.8
Provincial	32.8	5.7	23.6	5.5	23.1	5.9
Canada				4.8**		

* Based on ICD9 Chapter 11: Complications of Pregnancy, Childbirth and the Puerperium. Based on place of residence of patient.

** 1980/81

Source: Department of Health, Newfoundland and Labrador

Discussion Paper - Pediatrics

1.0 Introduction

Allocation of pediatric beds is considered to be within the overall bed guideline of 3.5 - 4.0 beds per 1000 population. However, pediatrics can to some degree be considered on its own as it serves a defined population and the beds required are not usually suitable for adult patients. The following is a summary of background information, and a discussion of anticipated future trends and recommendations for the allocation of pediatric beds.

For purposes of this paper and bed guideline development the population aged 0 - 14 has been used. Although the guidelines for Child Care Facilities in General Hospitals consider the population aged 0 - 19 as the pediatric population, the age group 15 - 19 "muddies the water" in terms of guideline development. Traditionally 0 - 14 has been considered to be the pediatric population and statistical reporting has been on that basis. Also, the 15 - 19 group tends to overlap with many adult specialties (e.g. obstetrics, psychiatry). The 15 - 19 group generally is adult size occupying adult beds, whereas the younger population tends to be provided with dedicated space in a pediatric unit and these units usually are unsuitable for the care of adult patients. Therefore, the following paper discusses inpatient bed requirements for the population aged 0 - 14.

2.0 Demographic & Utilization Trends

Table P-1.0 outlines demographic trends and certain hospital utilization trends for the province as a whole. Following are some points to note from this table.

1. The population aged 0 - 14 in the Province has declined from 194,500 in 1971 to 160,884 in 1983/84. Further declines are predicted in future.

2. Not only has this population declined in real numbers, but it also declined as a percentage of the total population from 37.3% to 27.9% of the population.

3. Utilization rates in terms of both separations and days per 1000 population have declined substantially from 1971 to 1983/84. Therefore, the total hospital days used by the pediatric population have declined.

4. Since pediatric beds usually cannot be used for adults because of the design of the facilities, the occupancy rates for pediatric units throughout the province are very low.

3.0 Discussion

A number of trends in pediatrics will affect future utilization of hospital beds. These include:

1. Declining population in the 0 - 14 age group.
2. Improved preventive health care.
3. Changing morbidity patterns (control of acute disorders but extending life spans of children with chronic diseases (e.g. renal failure, leukemia, etc.)
4. Increasing specialization and improvement in pediatric services in the regions (Note that provision of specialty (board certified) pediatricians reduces hospital admissions in most areas).
5. Emphasis on ambulatory care as the preferred method of care for both acute and chronic disorders.
6. Participation of a multi-disciplinary team in the care of children with disabilities.

As shown in Table P-1.8, many hospitals have already reduced pediatric beds and in some cases redesignated them for other uses. Others, although retaining the term "pediatric" have increased the age limit of patients treated in the pediatric beds.

4.0 Recommendations

The following guidelines are suggested to direct the review of pediatric beds throughout the province:

1. Pediatric beds should be designated as a special unit only in those hospitals which meet the following criteria:
   (a) There are at least two qualified pediatricians on the active staff of the hospital (or planned).
   (b) At least 15 beds are justified for the catchment area of the hospital according to the guideline.
   (c) The hospital can adapt to modern concepts of child care including parent rooming in and activity areas for play and school activities.

2. In the hospitals in which a pediatric unit is not justified (and this will be the vast majority of hospitals in the province) admission of children should be discouraged. However, in those few cases requiring admission but not requiring care by a pediatrician, a room in an adult medical/surgical unit should be equipped to provide pediatric care (i.e. provide a crib in an adult room). This should be a private or semi-private room preferably adjacent to the nursing station. Since those types of admissions should be short stay (maximum 48 hours) this policy should not mean an undue burden on adult beds. Children requiring a longer hospital stay should be transferred to a regional hospital under the care of a pediatrician.

If these guidelines are accepted it would not mean an instant changeover of all pediatric beds in the province. The following is suggested as an implementation strategy:

1. Any new hospitals planned should be constructed in accordance with the above guidelines.

2. Where community hospitals need additional acute or long term care beds, the appropriateness of renovating pediatric units to accommodate adults be considered as a first step prior to constructing additional space.

3. All new or renovated facilities should be planned so that rooms are appropriate for either adults or children.

Implementation of these policies would mean that the following hospitals would provide designated pediatric units:

- Western Memorial, Corner Brook
- Central Newfoundland, Grand Falls
- James Paton, Gander
- Janeway, St. John's

Although not justified according to these guidelines, geographic isolation and historical referral patterns suggest the need to retain beds at Melville Hospital in Goose Bay and Curtis Memorial in St. Anthony. Recommendations for these hospitals are located in the relevant section of this report.

Calculation of Bed Allocation Guideline

Table P-1.6 shows the historical trends in terms of average length of stay and separations per 1000 population aged 0 - 14.

For purposes of calculating beds at this time, it is recommended that the 1991 estimate of 1.5 beds per 1000 population aged 0 - 14 be used. However, over the next 5 - 10 years, further reductions should be anticipated. Note that these beds are included in the overall guideline of 3.5 - 4.0 acute care beds per 1000 total population.

Table P-1.3 shows by region of hospital location, the distribution of reported pediatric days in 1984-85. There is a substantial variation among the regions in the degree to which pediatric days are consolidated in regional centres. In the long run, it is anticipated that days in "community" hospitals (i.e. those without specialized pediatric staff) will be reduced further.

Table P-1.4 shows for 1983-84, the number of pediatric separations and days by patient origin, in total, and at the Janeway Hospital. While no trend analysis was done, it appears from this information reasonable to assume that on average 25% of patient days for all regions will occur at the Janeway. Although Northern region refers less than this percentage, this region is expected to refer a higher proportion of its patients to St. John's in future. Therefore, for purposes of planning on a guideline basis, we recommend assuming that 25% of the pediatric beds for the remainder of the province should be allocated to St. John's. The guideline breakdown is therefore recommended to be as follows:

For regions:

.75 x 1.5/1000 pop. = 1.125 beds per 1000 regional population

Additional for Janeway:

.25 x 1.5/1000 pop. = .375 beds per 1000 provincial population

Table P-1.0

Newfoundland and Labrador
Utilization Rates, Aged 0 - 14
1971 - 1984/85

	1971	1976	1981/82	1982/83	1983/84
Population	194,500	187,800	165,080	163,296	160,884
% of Population	37.3	33.7	28.7	28.5	27.9
% of Hospital Seps.	27.7	23.9	18.9	18.8	18.0
% Hospital Days Stay	22.4	18.2	13.5	13.2	12.8
Sep. Rate/1000	118	116	100	105	98
Days Stay Rate/1000	938	768	600	623	618
Length of Stay	8.0	6.6	6.0	6.0	6.3

* Source: Newfoundland and Labrador Department of Health

Table P-1.1

Population 0-14
Census and projected future, by Region
Newfoundland and Labrador
1971 - 2001

Region	1981	1986	Projected *		
			1991	1996	2001
St. John's	36,230	34,446	32,076	32,197	31,139
Eastern 2 - Avalon	28,090	27,194	26,183	24,078	21,302
Eastern 3 - Burin Bonavista	18,800	17,609	16,599	16,126	15,375
Central	38,230	34,380	31,131	29,261	26,329
Western	29,070	26,610	24,237	22,076	20,108
Northern	6,040	5,871	5,313	5,070	4,701
Labrador	10,940	9,829	8,749	8,020	6,913
Prov. Total	167,400	155,939	144,288	136,828	125,867

* Source: Royal Commission on Hospital and Nursing Home Costs

Table P-1.2

Separations and Days by Region
Population Aged 0 - 14

Region	Seps			Days		
	1982/83	1983/84	1984/85	1982/83	1983/84	1984/85
St. John's	2,632	2,443	2,398	18,307	17,454	18,473
Eastern II	2,566	2,361	2,543	16,562	17,318	17,830
Eastern III	1,867	1,812	1,753	10,997	12,086	11,069
Subtotal	7,065	6,616	6,694	45,866	46,858	47,372
Central	4,587	4,019	4,276	24,980	23,064	27,383
Western	2,926	2,546	2,731	16,420	15,453	14,902
Northern	1,520	1,486	1,258	9,461	8,667	7,132
Labrador	998	1,025	791	4,968	5,283	4,817
Total	17,096	15,692	15,750	101,695	99,325	101,606

Source: Hospital Days by Origin of Residence
Newfoundland and Labrador Department of Health

Table P-1.3

Reported Pediatric Days 1984-85 by Hospital Grouping

Region	Days in Regional Hospital (or Tertiary)	%	Days in Comm'ty** Hospital	%	Total
Labrador	2218 *	91.4	210	8.6	2428
Northern	4011 *	94.7	224	5.3	4235
Western	8767	74.8	2960	25.2	11727
Central	13338	86.3	2113	13.7	15451
Eastern	53217	100.0	-	100.0	53217
Total	81551	93.7	5507	6.3	87058

* Includes Melville, Jackman and St. Anthony although a pediatrician is not always available.

** All hospitals except the following: Jackman, Melville, Western, Central Newfoundland, James Paton, Carbonear, Janeway

Note: Patient days reported are substantially greater than those reported through the admission - separation system for patients aged 0 - 14. Because of differing age limits, these numbers cannot be considered accurate for pediatric utilization and should only be used for purposes of calculating proportions.

Source: Department of Health, Annual Returns of Hospitals

Table P-1.4

Separations & Days by Patient Origin (1983)
Patients aged 0 - 14

Region of Origin	Total Seps	Seps at Janeway	%	Total Days	Days at Janeway	%
Eastern	6,616	4,526	68.4	46,858	35,711	76.2
Central	4,019	417	10.4	23,064	5,898	25.6
Western	2,546	189	7.4	15,453	3,135	20.3
Northern	1,488	34	2.3	8,667	861	9.9
Labrador	1,025	98	9.6	5,283	1,593	30.2
Subtotal (All regions except Eastern)	9,078	738	7.4	52,467	11,487	21.5
GRAND TOTAL (All regions)	15,694	5,264	37.9	99,325	47,198	48.9

Source: Department of Health, Admission - Separation System

Table P-1.5

Separations/1000 pop. & Days/1000 pop. at Janeway Hospital
1983/84 by Region of Residence

Region of Origin	1983/84 est. pop.	Utilization of Janeway Hospital	
		Seps/1000	Days/1000
Eastern (total)	81,055	55.8	440.6
Central	36,455	11.4	161.8
Western	27,862	6.8	112.5
Northern	5,858	5.8	147.0
Labrador	10,392	9.4	153.3
Total	161,622		

Source: Department of Health Admission - Separation System

Table P-1.6

Calculation of Pediatric Bed Requirements
Province of Newfoundland

Project separation rate reductions per historical trend:

Year	0 - 14 Seps/1000
1971	118
1981	110
1983/84	98
1986	93
1991	85
1996	79
2001	72

Project average length of stay per historical trend:

Year	0 - 14 Average Stay
1971	8.0
1981	6.0
1983/84	6.3
1986	5.3
1991	4.5
1996	4.5 *

Projections - Hospital Days & Beds

Year	Seps/1000	Average Stay	Days/1000	Pop.	Days	Beds @ 70%	Beds/1000 0 - 14
1986	93	5.3	493	155939	76878	301	1.9
1991	85	4.5	383	144288	55262	216	1.5
1996	79	4.5	356	136828	48711	191	1.4
2001	72	4.5	324	125867	40781	160	1.3

* Probably will bottom out at this level, due to increasing complexity of care, if separation rate continues to decline.

Table P-1.7

Separations/1000 and Days/1000 Population Aged 0-14 by County of Residence in Nova Scotia (Excluding Newborns) 1981/82

County	1981 Population	Seps/1000 Population	Days/1000 Population	Average Stay
REGION 1	12,700	75	376	5.2
Lunenburg	9,840	71	378	5.3
Queens	2,860	77	369	4.8
REGION 2	15,035	96	493	5.1
Yarmouth	6,010	126	665	5.3
Digby	4,850	61	329	5.4
Shelburne	4,175	95	95	4.6
REGION 3	16,710	119	589	5.0
Annapolis	4,940	76	426	5.6
Kings	11,770	137	658	4.8
REGION 4	10,015	105	571	5.5
Colchester	10,015	105	571	5.5
REGION 5	7,645	162	829	5.1
Cumberland	7,645	162	829	5.1
REGION 6	12,615	108	516	4.8
Pictou	12,615	108	516	4.8
REGION 7	17,950	107	523	4.9
Antigonish	5,320	105	551	5.3
Guysborough	3,280	122	639	5.2
Richmond	3,310	64	324	5.1
Inverness	6,040	124	543	4.4
REGION 8	33,195	152	1,059	7.0
Victoria	2,010	111	496	4.5
Cape Breton	31,185	154	1,096	7.1
REGION 9	72,620	75	384	5.1
Halifax	64,180	71	367	5.2
Hants	8,340	109	510	4.7
N.S. TOTAL	198,485	103	569	5.5

Source: 1981 Census; County Run Separations and Days

Table P-1.8

Pediatric Bed Utilization Trends
1976/77 - 1984/85

Region	Hospital	Beds		Patient Days		% Occupancy	
		1976/77	1984/85	1976/77	1984/85	1976/77	1984/85
Labrador	Melville	6	6	1,244	1,380	56.8	63.0
	Churchill Falls	2	0	116	0	15.9	0
	Captain W. Jackman	14	12	2,294	838	44.9	19.1
	Makkovik	2	1	92	1	12.6	0.3
	Conche Nurse Station	2	0	0	0	0	0
	Hopedale	2	1	176	10	24.1	2.7
	Nain	0	4	0	138	0	9.5
	Forteau	3	1	142	56	13	15.3
	North West River	15	0	4,366	0	79.7	0
	Cartwright	3	1	45	5	4.1	1.4
Northern	Flower's Cove	5	0	44	2	2.4	0
	Roddickton	2	1	110	46	15.1	12.6
	C.S. Curtis Memorial	26	26	7,430	4,011	78.3	42.3
	Port Saunders	4	4	0	176	0	12.1
Western	Sir Thomas Roddick	16	22	4,282	2,325	73.3	29.0
	Burgeo	5	2	0	0	0	0
	Bonne Bay	8	0	0	0	0	0
	Western Memorial	36	25	11,603	8,767	88.3	96.1
	Channel	10	5	0	635	0	34.8
Central	M. J. Boylen	8	8	0	565	0	19.3
	James Paton Memorial	29	29	8,906	4,776	84.1	45.1
	Buchans	6	4	566	24	25.8	1.6
	Central Newfoundland	50	30	12,236	8,562	67	78.2
	Botwood	10	0	0	0	0	0
	Springdale	10	4	1,755	0	48.1	0
	Brookfield	11	4	0	316	0	21.6
	Harbour Breton	3	3	0	313	0	28.6
	Notre Dame Bay Mem.	10	10	2,471	895	67.7	24.5
	Fogo	0	0	0	0	0	0

Table P-1.8 (cont'd)

Pediatric Bed Utilization Trends
1976/77 - 1984/85

Region	Hospital	Beds		Patient Days		% Occupancy	
		1976/77	1984/85	1976/77	1984/85	1976/77	1984/85
Eastern III	St. Lawrence	5	0	0	*	0	0
	Grand Bank	10	9	0	*	0	0
	Come By Chance	4	4	0	*	0	0
	Burin	7	7	0	*	0	0
	Bonavista	2	3	0	*	0	0
Eastern II	Placentia	9	7	0	*	0	0
	Old Perlican	8	2	0	*	0	0
	Carbonear General	22	12	3,136	2,270	39.1	51.8
St. John's	Janeway	233	193	62,464	50,947	73.4	72.3
	Dr. W. Templeman	8	8	0	*	0	0
		606	448	123,478	87,058		

Note:
1) Figures exclude Children's Rehabilitation Centre.
2) Figures shown are for reported beds only. Some small hospitals have beds designated for pediatrics but do not report them as such.
3) Since pediatric beds may be used for overflow from medical-surgical units, all days reported as pediatrics are not necessarily used by children.

* Patient days included in medical surgical.

Source: Newfoundland Department of Health, Annual Return of Hospitals

Table P-1.9

Comparison Separation Rates /100,000 population by Region of Residence
Selected * Diagnoses (Cases aged 0 - 14)
1983/84 (Based on 1981 census pop.)

Diagnosis	Prov. Total	St. John's	Avalon	Burin - Bonavista	Central	Western	Northern	Labrador
Acute U.R.I.	786	301	584	952	1,030	953	1,291	1,042
Chronic Disorders & Anomalies	712	660	805	468	419	537	480	503
Pneumonia	516	287	413	500	557	519	1,291	1,143
Asthma	449	348	552	644	358	416	579 **	521 **
Non-Infective Enteritis & Colitis	395	213	438	426	445	389	695 **	521 **
Otitis Media	325	150	-	298	364	217	1,970	649
Other Disorders of Respiratory System	286	138	263	340	348	320	298 **	430
Appendicitis	237	190	295	250	207	224	-	384
Other Disorders of Urinary System	213	160	-	197	246	248	464	219
Other Reasons for Contact w Health Services	162	83	110	96	131	58	-	960 ***

* Top 10 provincial diagnoses
** Based on small numbers and should therefore be used with caution
*** May be anomaly-out of line with other years

Table P-1.10

Percentage of Separations staying 1 or 2 days Population aged 0 - 14, by region of origin 1982/83, 1983/84, 1984/85

Region	Percentage staying 1 or 2 days		
	1982/83	1983/84	1984/85
St. John's	42.3	39.3	32.7
Avalon	41.4	38.0	31.4
Burin Bonavista	39.0	39.9	30.5
Total Eastern	41.1	39.0	31.6
Central	39.2	33.2	33.7
Western	40.6	38.5	38.7
Northern	42.8	42.9	41.3
Labrador	49.1	43.8	39.9
TOTAL	41.1	38.1	34.6

Source: Hospital Morbidity file, Newfoundland & Labrador Department of Health

Table P-1.11

Comparison of Physicians Stock & Estimated Requirements
Specialty - Pediatrics
1983

Location	Physician Stock 1983		Estimate of 1983 Physician Requirements
	Cert	Non-cert	
St. John's	22	-	20
Carbonear	-	-	1
Gander	-	1	2
Grand Falls	1	1	2
Twillingate	1	-	1
Corner Brook	1	2	3
St. Anthony	-	-	1
Labrador	-	-	1
Total	25	4	31

Source: Newfoundland & Labrador Department of Health

Discussion Paper
Minimum Size of Hospitals and Nursing Homes

1.0 Hospitals

Traditionally, acute care hospitals have been health care facilities whose primary activity was the provision of diagnostic and treatment services to inpatients. Within that context, it made sense to establish minimum "economic" units in which to perform such functions. Because of nursing staff ratios, in particular, and the need to provide at least minimum staffing on a 24 hour basis, it was increasingly recognized that small nursing units (e.g. less than 20 beds) were uneconomic to staff. It generally became recognized that for unspecified adult beds, 25 - 30 was an economic size of unit to staff.

As hospitals developed more complex equipment and staffing requirements, particularly in the support services, it became recognized that in order to justify the support services and equipment to keep practice at a high quality level, multiples of 25 - 30 bed nursing units were required to provide an "efficient" service. Hospital planners then looked at varying numbers from 50 - 400 beds as being the most "economical" hospital.

During the past two decades, however, major changes have occurred in the role of hospitals. Increasingly they are centres for ambulatory preventive, diagnostic and treatment services. The hospital can no longer be adequately described only by the number of inpatient days it provides, and "per bed" ratios are increasingly recognized as not very meaningful. The hospital is a collection of resources which provides services to people on both an inpatient and outpatient basis.

There are a number of other factors to consider in discussing minimum size of hospitals. If the "hospital" is to provide only "emergency" services to patients who must be stabilized before transport to another facility, then a certain number of beds would be required. If, because of distance to other facilities and the availability of local resources, it is more appropriate to treat certain types of patients locally (e.g. myocardial infarctions, infants with respiratory problems, unstable diabetics, etc.), in addition to stabilization of acutely ill patients, then another level of beds will be required. If, in addition, it is agreed that obstetrics and/or surgery will be provided, still another level of beds will be required. Clearly, the size of hospital must relate to the role of the facility.

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In Newfoundland, geography plays an important role in the way health care services are delivered. There are many communities which are isolated by water or by long road distances. Geographic factors must therefore be weighed against economies of scale.

Still another factor which impacts on the minimum size of hospitals is multi-unit management and the degree of sharing or integration with related facilities. There are obviously cost implications in operating a fully staffed, fully equipped free standing 10-bed hospital versus operating a 10-bed acute care unit attached to a 75-bed nursing home, or a 10-bed acute care hospital which is part of a mult-unit management system.

Another factor to be considered is the physical layout of the building. Private and semi-private rooms allow much greater flexibility of use than do large open wards. Therefore, it is possible to provide a larger volume of patient days in a smaller capacity in one and two bed rooms.

The attached graphs from the Royal Commission suggest that hospitals in the 0 - 24 bed group are more costly per patient day, and the rate of rise in costs is greater in this size than in any other size group in Newfoundland. On the surface, this information would suggest that this hospital size group is the least efficient and that all hospitals should, therefore, be larger than 25 beds. Unfortunately, this would be a gross oversimplification of the situation.

In reality, the problem is that Newfoundland has too many beds in small hospitals for the services that those hospitals are providing. Because of increasing specialization and use of technical equipment, inpatient care has become more and more centralized in regional facilities. Patient days have, therefore, declined in small hospitals. By and large, staffing has remained the same because of minimum coverage requirements and therefore unit costs have risen. Also, the volume of outpatient services in these hospitals has increased, and inpatient staff in most cases also provide outpatient services. These factors are not reflected in "per patient day" statistics.

We do not believe, therefore, that it is appropriate to develop a theoretical minimum size of hospital for Newfoundland. Rather, the number of beds to be provided in each area should be reviewed within the context of provision of current and future services, distance from other health facilities, and management and physical limitations. While a 10-bed free-standing acute care hospital is unlikely to be efficient, its efficiency could undoubtedly be improved if it were constructed adjacent to another facility providing 24-hour care (such as a nursing home) with sharing of major support services (e.g. dietary, housekeeping, administration). Also, there are clearly certain services for which it would be dangerous for patients to travel long distances, while for others there is no danger, but only inconvenience and cost which must be weighed against the benefits of centralization.

In discussing bed requirements with most small hospitals not doing surgery, the vast majority felt that an acute care allotment of approximately 10 beds would adequately meet their needs for provision of medical, normal obstetrics and primary pediatric care. Although 10 is clearly not an efficient nursing unit, let alone a hospital size, it is a reasonable number to attach to another facility such as a nursing home, assuming substantial sharing of staff between acute and long term care and ambulatory care.

Given the many trends in hospitals and health care services, Newfoundland should not consider constructing hospitals in any new locations in the province. There are, however, a number of small hospitals which will require replacement over the next 5 - 10 years. When such construction occurs, it should be based on the beds required to fulfill the defined role within the context of distance, management system, etc., and excess numbers should not be built in order to provide a theoretically efficient nursing unit. It is well known and well documented that excess capacity leads to overutilization and this phenomenon is to be discouraged.

2.0 Nursing Homes

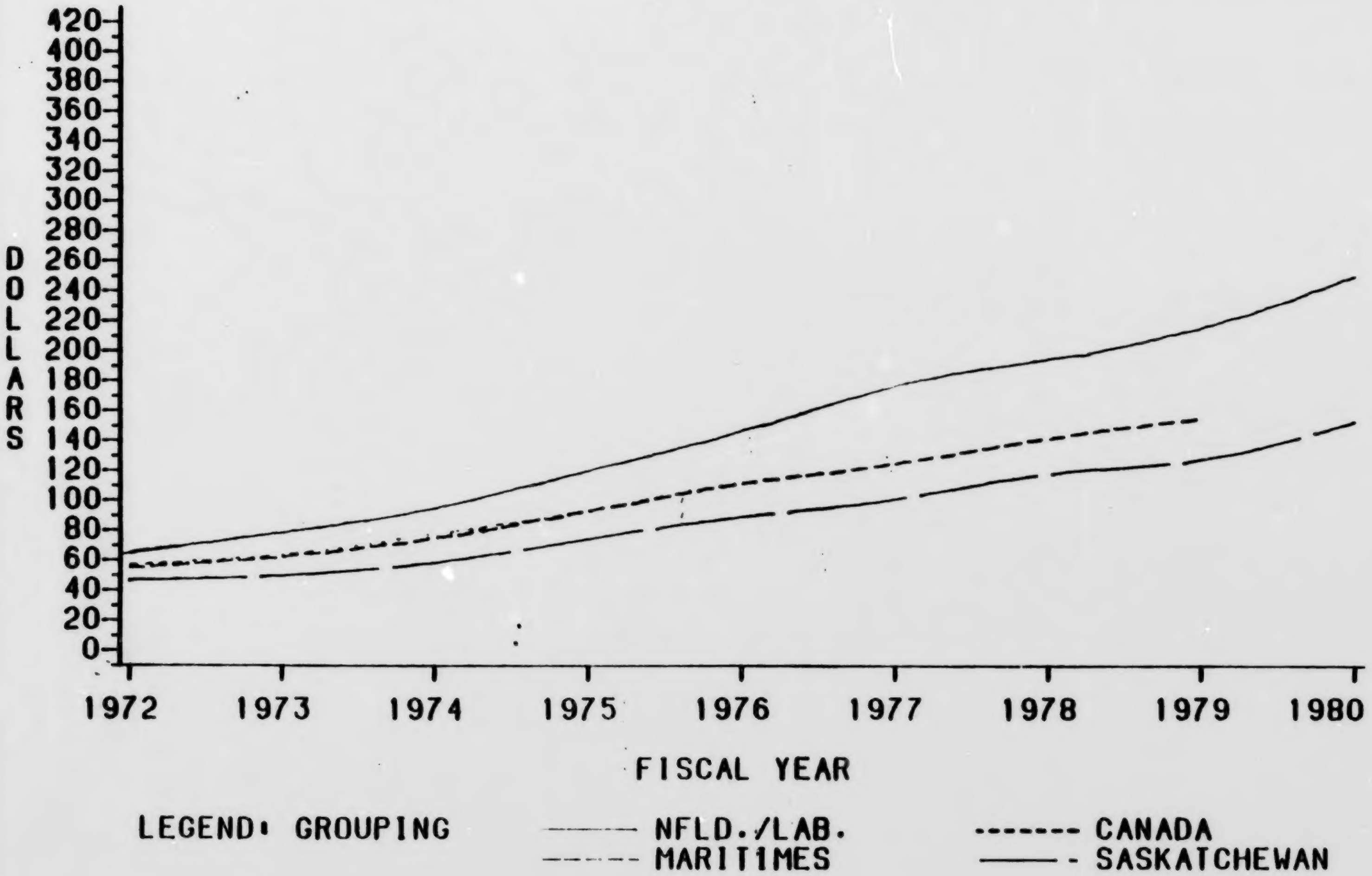
There appears to be general agreeement among nursing home administrators that 75 beds is the minimum economical size for a nursing home. No maximum size was agreed upon, but all agreed that too many beds would encourage an institutional atmosphere.

While the 75 bed minimum size may have some validity for a free standing independent facility, it holds little validity within the context of multi-unit management. Nursing homes in future should be regarded as part of a long term care system which includes both institutional and non institutional services. Long term care facilities should operate in very close relationship with acute care facilities, with the maximum possible sharing of services.

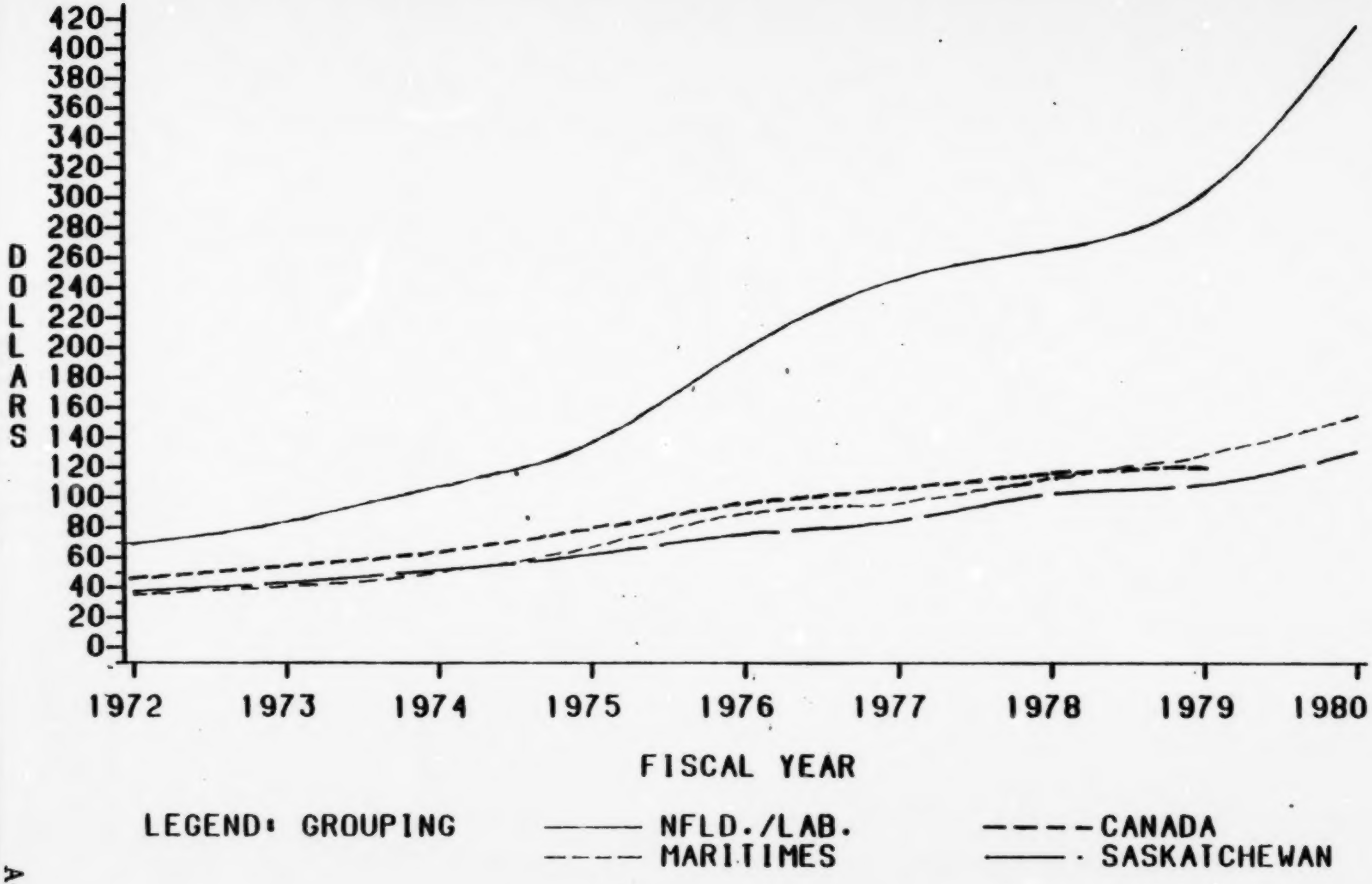
Provision of excess capacity in nursing homes is unacceptable within the framework of providing services to encourage independent living. Building too many beds in order to create an "economic" unit is not justified as it leads to inappropriate placement and encourages dependency on institutional services.

We therefore do not consider it appropriate to recommend a minimum or maximum size of nursing home to be adopted for Newfoundland. Instead, bed numbers provided in each area should be considered according to estimated need and within the context of management systems and available resources.

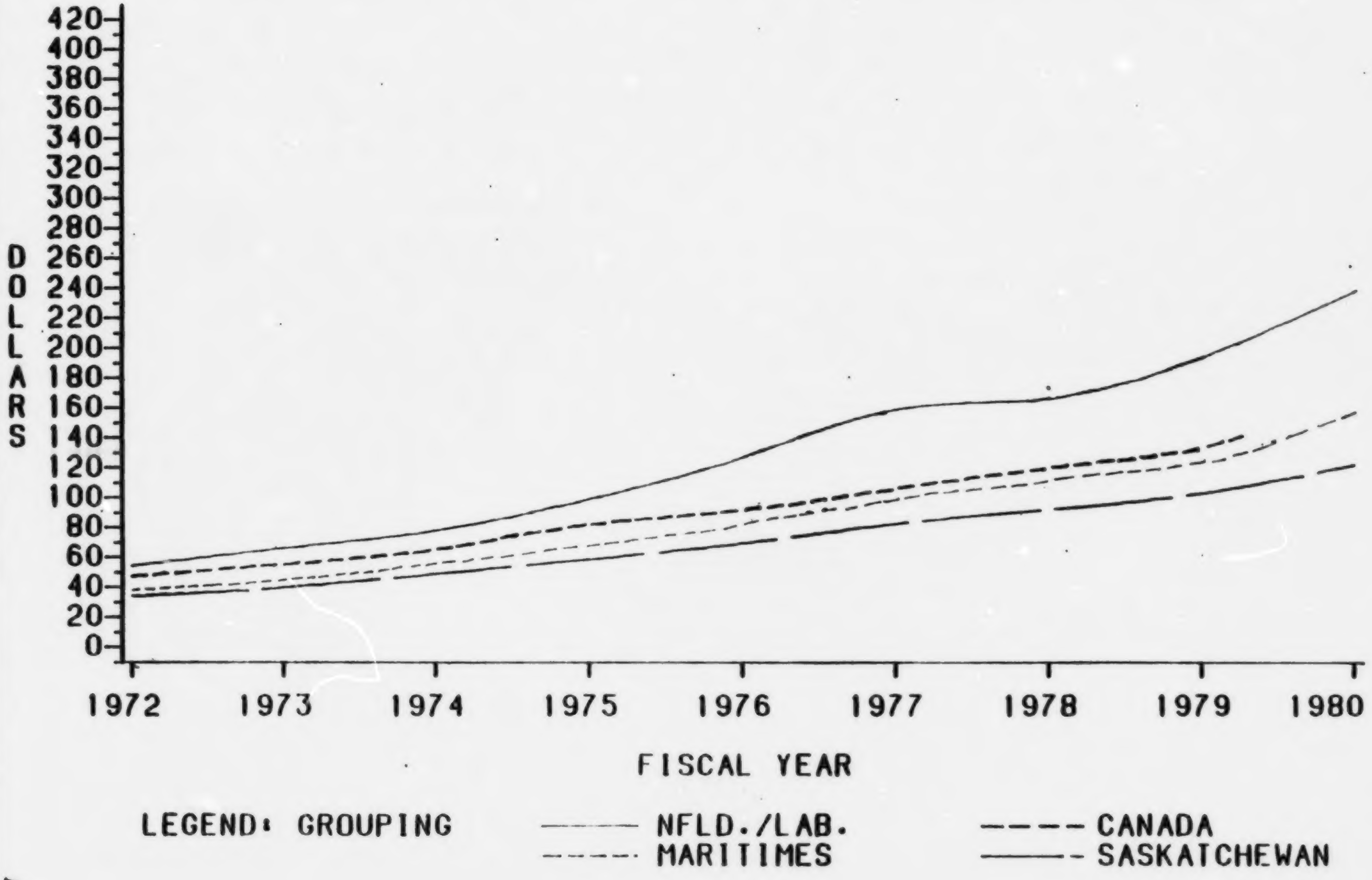
NFLD./LAB. ROYAL COMMISSION ON HOSPITAL & NURSING HOME COSTS
MEAN TOTAL OPERATING COSTS PER PATIENT--DAY FOR ALL HOSPITALS



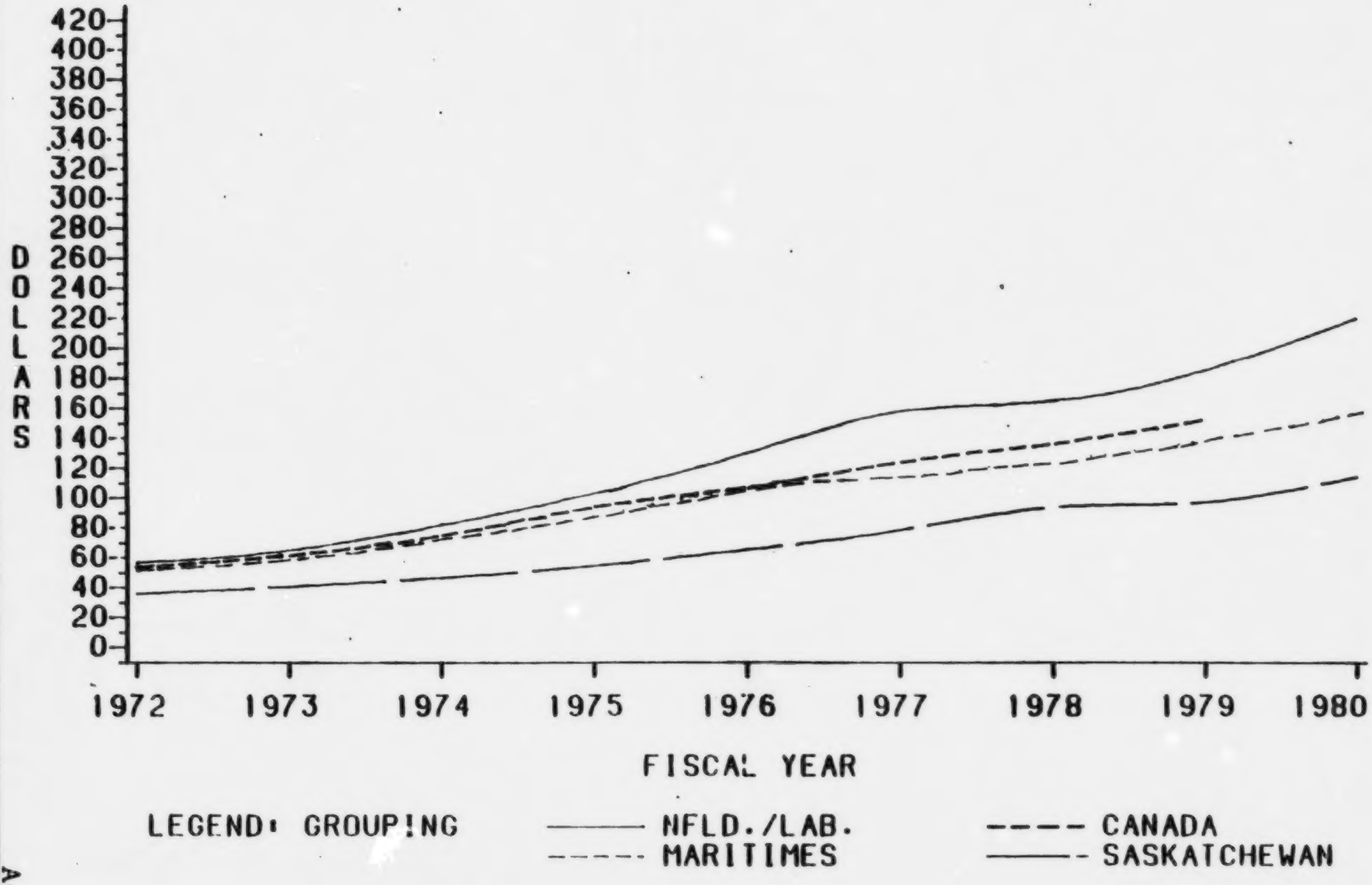
NFLD./LAB. ROYAL COMMISSION ON HOSPITAL & NURSING HOME COSTS
MEAN TOTAL OPERATING COSTS PER PATIENT–DAY FOR HOSPITALS WITH 0–24 BEDS



NFLD./LAB. ROYAL COMMISSION ON HOSPITAL & NURSING HOME COSTS
MEAN TOTAL OPERATING COSTS PER PATIENT-DAY FOR HOSPITALS WITH 25-49 BEDS



NFLD./LAB. ROYAL COMMISSION ON HOSPITAL & NURSING HOME COSTS
MEAN TOTAL OPERATING COSTS PER PATIENT-DAY FOR HOSPITALS WITH 50-199 BEDS



NFLD./LAB. ROYAL COMMISSION ON HOSPITAL & NURSING HOME COSTS
MEAN TOTAL OPERATING COSTS PER PATIENT-DAY FOR HOSPITALS WITH 200--550 BEDS

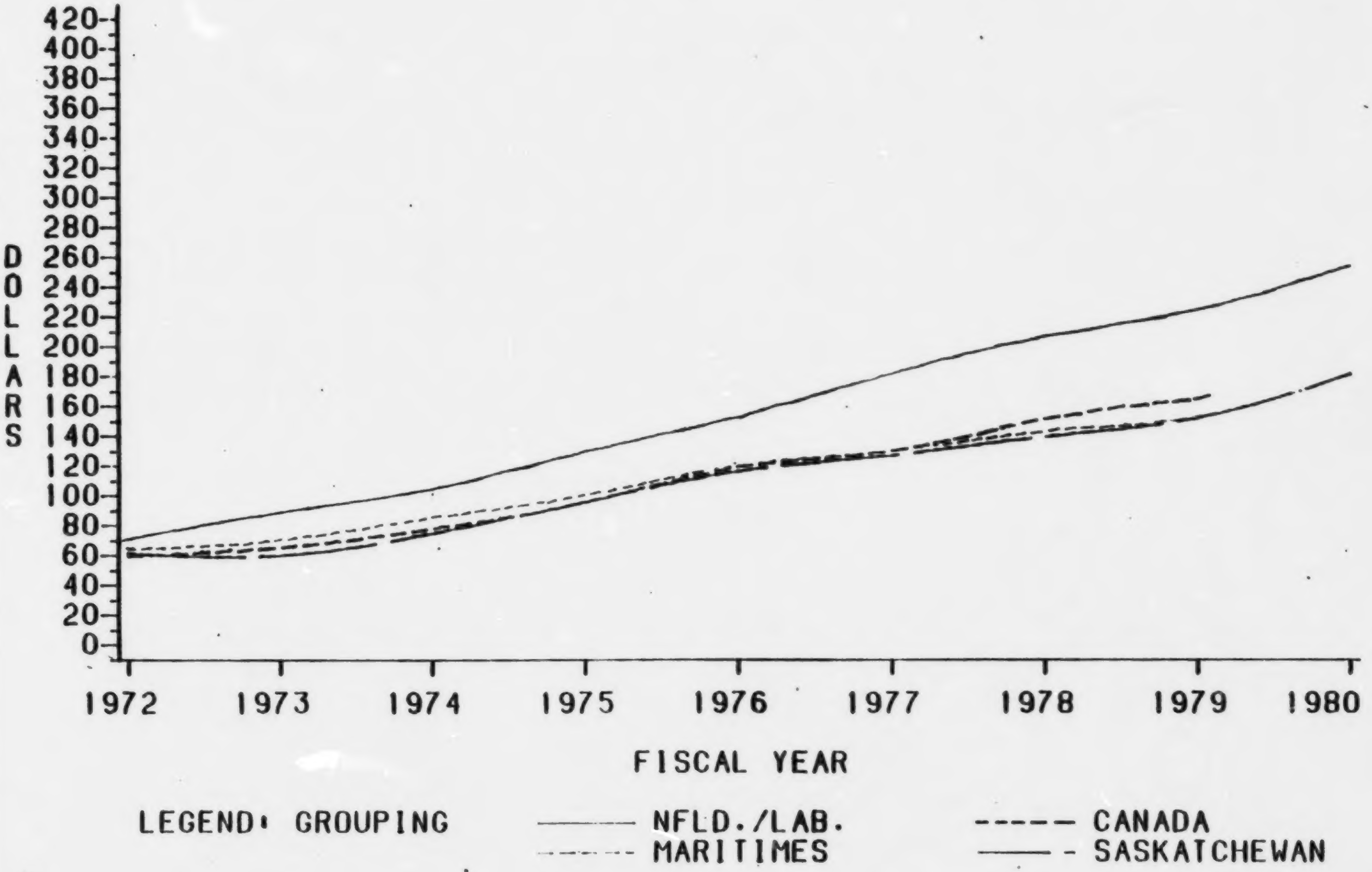


Table A-1

Comparison of Beds Set Up
And Occupancy Rates - By Region
1976/77 and 1983/84

Region	Hospital	Beds Set Up *		Occupancy Rates**	
		1976/77	1983/84	1976/77	1983/84
Labrador	Melville	40	55	58.6	74.0
	Churchill Falls	14	0	10.1	0.0
	Jackman	51	51	70.0	44.7
	Makkovik	6	4	17.1	2.9
	Hopedale	6	3	20.9	17.1
	Nain	7	14	79.5	26.1
	Northwest River	45	0	75.0	12.0
	Forteau	10	6	26.6	22.1
	Mary's Harbour	13	8	5.5	0.2
	Cartwright	11	8	6.7	3.6
	Subtotal	203	149		
Northern	Flowers Cove	13	2	8.2	7.3
	Roddickton	6	4	34.8	35.6
	Conche	6	0		
	Curtis	131	146	86.9	67.1
	Port Saunders	16	16	15.1	36.5
	Subtotal	172	168		
Western	Roddick	80	89	71.5	65.6
	Burgeo	18	14	46.5	53.6
	Bonne Bay	28	26	37.1	32.3
	Western	263	279	78.5	78.2
	Channel	37	37	79.9	55.8
	Subtotal	426	445		
Central	Boylen	40	39	48.1	50.7
	Paton	154	162	69.9	67.0
	Buchans	22	22	42.8	16.8
	Central Nfld	219	201	68.8	78.6
	Botwood	53	48	51.4	50.3
	Springdale	31	25	47.7	66.3
	Brookfield	40	30	39.7	46.5
	Fogo	18	18	23.2	31.1
	Harbour Breton	17	19	58.0	46.8
	Notre Dame Bay	54	71	83.3	53.0
	Subtotal	648	635		

Table A-1 (cont'd)

Comparison of Beds Set Up And Occupancy Rates - By Region 1976/77 and 1983/84

Region	Hospital	Beds Set Up		Occupancy Rates	
		1976/77	1983/84	1976/77	1983/84
Eastern III	St. Lawrence	22	22	62.2	36.9
	Grand Bank	33	32	34.3	29.4
	Come by Chance	26	24	56.7	63.4
	Burin	31	31	59.4	51.1
	Bonavista	16	16	75.1	63.4
	Subtotal	128	125		
Eastern II	Placentia	34	35	56.8	41.2
	Old Perlican	44	15 ***	40.7	60.8
	Carbonear	96	100	57.0	76.5
	Subtotal	174	150		
St. John's****	Janeway	233	193	73.4	80.9
	Templeman	40	40	30.5	43.3
	General	302	342	89.3	92.8
	Grace	306	292	86.2	92.1
	St. Clare's	345	323	89.9	85.0
	Waterford		446		96.1
	Miller Centre		182		84.0
	Children's Rehab.		42		13.0
	Subtotal	1226	1860		
TOTAL		2977	3532		

* Source: Royal Commission on Hospital & Nursing Home Costs
** Source: Department of Health reports
*** Source: Visit information
**** Source: St. John's Hospital Council

Table A-2

Hospital Beds in Operation by Region and by Type as reported during consultants' visits and summary of long term patients occupying acute care beds

Region/Hospital	Beds Set Up, 1985 Acute Care	Long Term Care	Psych. Care	Long Term Care Patients in Acute Care Beds
Labrador				
Cptn Wm Jackman Hospital	43			1
Melville Hospital	51			2
Others	24			
Total	118			3
Northern				
C.S. Curtis Mem'l Hosp	130		16 *	5
Roddickton	4			
Flower's Cove	2			0
Port Saunders Hospital	16			3-5
Total	152		16 *	8-10
Western				
Western Mem'l Hospital	267	30	25	8
Sir Thomas Roddick	73	16		2
Charles L. LeGrow	40			7
Burgeo Hospital	15			0
Bonne Bay Hospital	15	6		
Total	410	52	25	17
Central				
M.J. Boylen Hospital	31	8		10
A.M. Guy Mem'l Hospital	2	18		
Cntl Nfld Reg Hlth Cntr	174		20	12-20
Springdale Hospital	25			2
Botwood Cottage Hosp	46			14
Notre Dame Bay Mem Hosp	54	15		
Fogo Hospital	18			
James Paton Mem Hosp	147		10	6
Brookfield Hospital	30			1
Harbour Breton Hospital	19			0
Total	546	41	30	45-53

Table A-2 (cont'd)

Region/Hospital	Beds Set Up, 1985			Long Term Care Patients in Acute Care Beds
	Acute Care	Long Term Care	Psych. Care	
Eastern III				
Dr. G. B. Cross Hospital				
Bonavista Cottage Hosp	15	0		12
Burin Cottage Hospital	31	0		0
U..S. Memorial Hospital	22	0		1
Grand Bank Cottage Hosp	30	0		4
Come by Chance Cott Hosp	24			
Total	122	0		17
Eastern II				
Placentia Cottage Hosp	35	0		
Old Perlican Hospital	15	0		7
Carbonear General Hospital	86			10
Total	136	0		17
St. John's				
Grace	267	0	25	7
St. Clare's	299	0	24	30
Health Sc. Centre	322		20	15
Waterford (Psyc)			446	
Janeway	193			
Children's Rehab		42		
Templeman	40			
Miller Centre		182		
Total	1121	224	515	52
Grand Total	2605	317	586	166

* Staffed 16 hours per day.

Table A-3

Acute Care Beds in Use, 1985 as Reported During Visits *
(excludes psychiatry)

Region	Acute Beds in Use	1981 Pop.	Beds/1000	1986 Pop.	Beds/1000
St. John's	1,121	138,565	8.1	144,771	7.7
Avalon	136	96,780	1.4	102,155	1.3
Burin/Bonavista	122	61,520	2.0	63,409	1.9
Subtotal	1,379	296,865	4.6	310,335	4.4
Central	546	124,066	4.4	125,175	4.4
Western	384	96,455	4.0	97,012	4.0
Northern	142	18,855	7.5	20,041	7.1
Labrador	141	31,315	4.5	30,798	4.6
Total	2,592	567,556	4.5	583,361	4.4

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* Hospitals not visited are included as per reported beds on 1983/84 Annual Return

Table A-4

Acute Care Beds in Use 1985
Minus Beds Occupied by Long Term Patients
(as reported on visits)

Region	Acute Beds* in Use	Beds Occupied by Long Term Care	Available for Acute Care	1981 Pop.	Beds/1000	1986 Pop.	Beds/1000
St. John's	1,121	52	1,069	138,565	7.7	144,771	7.4
Avalon	136	25	111	96,780	1.1	102,155	1.1
Burin/Bonavista	122	17	105	61,520	1.7	63,409	1.7
Subtotal	1,379	94	1,285	296,865	4.3	310,335	4.2
Central	546	53	493	124,066	4.0	125,175	3.9
Western	384	17	367	96,455	3.8	97,012	3.8
Northern	142	10	132	18,855	7.0	20,041	6.6
Labrador	141	1	140	31,315	4.5	30,798	4.5
Total	2,592	175	2,417	567,556	4.2	583,361	4.2

* Excluding Psychiatry.

Table A-5

Summary by Nursing Home of Residents & Waiting List

Facility	Current Residents			Waiting List excl. other NH		
	III	II	I	III	II	I
Paddon Home	37	8	6	1	1	4
St. Anthony Interfaith	19	17	12	7	10	10
Corner Brook Interfaith	34	17	51	0	0	68
Western Memorial	30	30	-			
Bay St. George	43	20	15	29	15	19
Valley Vista	37	25	16	11	32	32
Carmelite House	42	41	19	27	29	30
North Haven Manor	48	19	4	114	63	30
Bonnews Lodge	23	10	12	25	26	25
Lakeside Homes	68	20	35	56	39	73
Golden Heights Manor	35	11	1	33	21	4
Blue Crest Interfaith	54	14	26	37	21	4
Harbour Lodge	98	-	-	150	-	-
Carbonear Interfaith	55	-	-	8	-	-
Pentecostal *	27	25	49	32	14	7
Agnes Pratt	30	18	20	-	-	5
Escasoni	189	-	2	(incl in Hoyles Hme)		
Hoyles	238	11	-	264	322	8
Glenbrook	72	11	39	306	51	159
Masonic Park	42	5	-	58	129	33
St. Luke's	81	29	22	162	58	207
St. Patrick's	167	47	-	61	98	92
Grand Total	1469	378	329	1381	929	810

Source: Survey of Nursing Homes, December 1985

* Waiting list numbers for this home are totals as home reported it does not have information on current living situation of applicant.

** This is a gross estimate and contains much duplication and no relation to need.

Table A-6

Waiting List* Information by Location
Level II and Level III

Region	Facility	Total	Hospital	Other Nursing Home	Home of Friend/ Relative	Own Home	Boarding Home
Labrador	Paddon Home	2	1		1		
Northern	St. Anthony Interfaith	21		4	17		
Western A	Interfaith Home for Senior Citizens						
Western B	Bay St. George Senior Citizens Home	46	22	2	15	7	
	Subtotal, Western	46	22	2	15	7	
Central A	Valley Vista	44	11	1	24	7	1
B	Carmelite House	65	14	9	31	7	4
C							
D	North Haven Manor	185	51	8	119	4	3
E	Lakeside Home	110	18	15	44	21	12
	Bonnews Lodge	64	11	13	23	8	9
	Subtotal, Central	468	105	46	241	47	29
Eastern 3A	Golden Hts Manor	57	7	3	24	17	6
3B	Blue Crest	63	11	2	12	29	9
	Subtotal, Eastern 3	120	18	5	36	46	15
2A	Harbour Lodge	150**					
	Carbonear Interfaith	9	8	1			
	Pentecostal	46	***	***	***	***	***
2B	---	-	-	-	-	-	-
	Subtotal, Eastern 2	205	8	1			

Table A-6 (cont'd)

Waiting List* Information by Location
Level II and Level III

Region	Facility	Total	Hospital	Other Nursing Home	Home of Friend/ Relative	Own Home	Boarding Home
Eastern 1B	Agnes Pratt						
	Escasoni	****					
	Hoyles	586	93		273	220	
	Glenbrook	422	47	65	106	181	23
	Masonic	117	63	3	24	22	5
	St. Lukes	234	90	14	107	5	18
	St. Patricks	174	51	15	26	58	24
	Subtotal, Eastern 1	1533	344	97	536	486	70
	Total, Eastern	1858	370	103	572	532	85
	GRAND TOTAL	2395	498	155	846	586	114

---

* Waiting lists do not necessarily accurately reflect those in 'need' of nursing home care.

** No breakdown provided. These may be duplication of Hoyles Home.

*** This home does not know this information.

**** Included with Hoyles.

Table A-7

Bed Inventory
Long Term Care Beds by Levels
(excluding Boarding Homes)

Region	Facility	1986 Capacity			Suitable for all Level II & III
		Level II & III	Level I	Total	
Labrador	Paddon Home	46	6	52	yes
Northern	St. Anthony Interfaith	36	12	48	yes
Western A	Corner Brook Interfaith	51	51	102	yes
	Western Memorial Special Care Unit	52	-	60	yes
	Western Memorial Hospital	30	-	30	
	Subtotal	133	51	192	
Western B	Bay St. George Senior Citizens Home	63	15	78	yes
	Channel Hospital	18	-	18	yes
	Subtotal	81	15	96	
Central A	Valley Vista	67	36	103	yes
	M. J. Boylen Hospital	8	-	8	yes
	Subtotal	75	36	111	
Central B	Carmelite House	83	19	102	no
	A. M. Guy Hospital	18	-	18	yes
	Subtotal	101	19	120	
Central C	-	-	-	-	
Central D	Notre Dame Hospital	15	-	15	yes
	North Haven Manor	72	4	76	yes
	Subtotal	87	4	91	
Central E	Lakeside Home	88	35	123	yes
	Bonnews Lodge	35	10	45	yes
	Subtotal	123	45	168	

Table A-7 (cont'd)

Region	Facility	1986 Capacity			Suitable for all Level II & III
		Level II & III	Level I	Total	
Eastern 3A	Golden Heights Manor	46	1	47	yes
Eastern 3B	Blue Crest Interfaith	68	26	94	yes
Eastern 3C					
Eastern 2A	Harbour Lodge	98	-	98	yes
	Interfaith Citizens Home	55 *	-	55 *	yes
	Pentecostal Senior Citizens Home	57	45	102	yes
	Subtotal	210	45	255	
Eastern 2B	Lions Manor	75	-	75	yes
Eastern 1A					
Eastern 1B	Agnes Pratt	48	20	68	no
	Escasoni	189	2	191	yes
	Glenbrook Lodge	104	42	146	
	Hoyles Home	249	-	249	yes
	Masonic Park	42	-	42	
	St. Luke's	110	22	132	
	St. Patrick's	214	-	214	
	Subtotal**	956	86	1042	
	Total	2037	346	2391	

Yes = Yes with renovations

* 12 of these beds occupied by young mentally handicapped persons.
** Excludes CNIB Hostel

Note: Respite beds are included in the numbers shown above for level II & III care however, for purposes of calculating beds required, respite beds will be recommended outside the 40/1000 norm.

Note: Excludes Waterford and Miller Centre beds.

Table A-8

Capacities & Occupancy Rates
Licensed Boarding Homes, Newfoundland & Labrador
(January 31, 1986)

Region & District	Licensee	Location	Capacity	Total Residents	Vacant Beds
Eastern 1A	Barton	Goulds	13	13	
	Butler	Kelligrews	12	12	
	Canning	Manuels	36	34	2
	Chafe	Petty Hbr	7	7	
	Coady	Torbay	12	12	
	Crawley	St. Mary's	15	15	
	Dinn	Mt. Carmel	15	15	
	Dinn	Witless Bay	28	26	2
	Dunne	Mt. Pearl	5	4	1
	Fahey	Fermeuse	20	18	2
	Glynn	Bay Bulls	13	13	
	Halliday	Manuels	17	17	
	Hennessey	Kilbride	12	12	
	Kelly	Goulds	16	13	3
	Keough	Holyrood	26	26	
	Kirby	Holyrood	15	15	
	Lewis	St. Mary's	19	18	1
	Maloney	Goulds	4	4	
	Murphy	Paradise	15	14	1
	O'Neill	Goulds	11	11	
	Pardy	Kelligrews	17	16	1
	Pennell	Trepassey	18	17	1
	Perrin	Long Pond	35	31	4
	Piercey	Kelligrews	19	17	2
	Quinlan	Holyrood	16	15	1
	Smith	Kelligrews	20	20	
	Sturge	Mt. Pearl	17	17	
	Walsh	Bay Bulls	10	9	1
	Wettlaufer	Foxtrap	14	14	
	Woodford	Holyrood	9	9	
	Woodford	Holyrood	43	43	
	Subtotal		529	507	22

Table A-8 (cont'd)

Region & District	Licensee	Location	Capacity	Total Residents	Vacant Beds
Eastern 2A	Barrett	Old Perlican	20	20	
	Chaulk	South River	26	24	2
	Earle	Shearstown	12	11	1
	Gosse	Spaniard's Bay	15	15	
	Legge	Whiteway	15	14	1
	Marshall(C)	Brigus	30	19	11
	Marshall(F)	Brigus	8	7	1
	Norman	Bay Roberts	6	6	
	Tetford	Shearstown	16	15	1
	Wareham	Carbonear	15	15	
	Wilcox	Shaw's Lane	8	8	
	Subtotal		171	154	17
Eastern 2B	King	Dunville	20	20	
Eastern 3A	Jones	Port Rexton	4	4	
Eastern 3C	Fewer	Clarenville	32	28	4
	Greening	Musgravetown	20	20	
	Moss	Lethbridge	17	13	4
	Blundon	Hickman's Hbr	20	14	6
	Subtotal		89	75	14
	Total, Eastern		813	760	53
Central B	Faulkner	Bishop Falls	20	20	
Central D	Porter	Porterville	44	38	6
Central E	Banks	Ladle Cove	20	20	
	Guy	Musgrave Hbr	20	*	
	Subtotal		104	78	6
	Total, Central		104	78	6

Table A-8 (cont'd)

Region & District	Licensee	Location	Capacity	Total Residents	Vacant Beds
Western A	Brake	Corner Brook	5	5	
	Elliot	Corner Brook	3	3	
	Pike	Corner Brook	5	5	
	Xavier House	Corner Brook	20	18	2
	Pinsent	Deer Lake	20	20	
	Subtotal		53	51	2
Western B	Hilliard	Cape Anguille	3	3	
	Kendell	Piccadilly	4	4	
	Subtotal		7	7	
	Total, Western		60	58	2
Northern	Canning	Roddickton	20	20	
	Total, Northern		20	20	
Labrador	Embanks	Happy Valley	10	10	20
	Total, Labrador		10	10	20
	Grand Total		1007	926	61

* New Home - Information not available.

GOVERNMENT OF NEWFOUNDLAND AND LABRADOR
DEPARTMENT OF HEALTH

May 3, 1985 ST. JOHN'S

Mr. William Nycum & Associates Ltd.
6050 Almon Street
Suite 1
Halifax, Nova Scotia
B3K 1T8

Dear ~~Sirs~~ Bill:

RE: RFP FOR PROVINCIAL BED STUDY

In 1984 the Royal Commission on Hospital & Nursing Home Costs presented its Report to Government. The Report, a comprehensive detailed document, contains 217 recommendations and represents a blue-print for the future for both institutional and non-institutional services. Cabinet recently endorsed all of the recommendations of the Commission Report.

Among other things, the Commission indicated that there are too many acute care beds in the Province (approximately 350) but there is a need for additional nursing home or chronic care beds (approximately 700) as well as an expansion in home care/community-based programs. The Commission recommended that a detailed provincial bed study be conducted by region and by hospital to determine:

(a) insofar as possible the role and service function of each region and hospital;

(b) the requirement for general hospital beds up to the year 2000;

(c) the potential for present reduction of beds to realize some or all of the savings attributable to the closing of 355 beds (or thereabouts, depending on the impact of the new facilties presently being constructed).

The Commission also suggested that the study take into account at least the following factors:

(a) trends in occupancy levels, particularly by size of hospitals and type of service within hospitals;

(b) projected referral patterns, taking into account the ability of smaller facilities to attract and retain specialist physicians, and the potential addition of new "subspecialties" based in St. John's;

(c) the impact of improvements in technology such as slow-scan video and other data transmission capabilities which may enable "remote" specialist consultations and reduce diagnostic admissions;

(d) the impact of possible changes in the physician fee schedule which may provide more appropriate remuneration for non-hospital-based and preventive services;

(e) the impact of improved home support services which may both lessen re-admissions and shorten the length of stay;

(f) the impact of further emphasis on day care, day surgery programs and short stay clinical investigation units;

(g) the impact of additional nursing home facilities and home support services which will reduce the number of medically-discharged chronic care patients occupying acute hospital beds;

(h) the impact of present and proposed "hostel" units on hospital admission and length of stay patterns;

(i) the establishment of a "target norm" for the number of acute hospital beds per 1,000 population. At present, following the reduction of 131 beds, the ratio stands at 5.4 beds per 1,000 for a population of 570,000. The planned addition of 90 beds will provide a ratio in excess of 5.5 for the same population. The reduction of 355 "excess" beds would, again for 570,000 population, leave total acute beds of 2,810 or 4.9 beds per 1,000. While not recommending any specific figure, the Commission believes that a figure lower than 4.0 is a reasonable type of figure to establish, and strongly recommends that such a figure in fact be established as a matter of policy in order to assist and ensure future rational planning;

(j) the establishment of a minimum size for new hospital facilities. Again the Commission is not able to recommend a specific figure, but points out that inpatient facilities of 15-20 beds do not represent efficient delivery units from either an economic or a clinical point of view and that accessibility of quality care may be better provided through emphasis on clinic facilities with holding beds and stabilization capacity, improved transportation systems, and more widespread use by physicians of the "remote" technological assistance referred to above.

With respect to nursing home/chronic care beds, the Commission recommended that plans be developed for the construction of 700 new beds to accommodate non-ambulatory nursing care residents in accordance with a norm of 40 beds per 1,000 population 65 years and older.

The Commission also recommended that the four year plan for nursing home construction (400 to 500 new beds) established by Government in 1982 be implemented but that serious consideration be given to regional disparities in terms of the distribution of these nursing home beds. (It should be noted that these bed numbers are included in the total number recommended by the Commission.) As well, since the Commission's Report was presented to Government, it has received dozens of requests from communities throughout the Province for nursing home beds.

The Department of Health now is inviting proposals from experienced firms to conduct a detailed bed study in accordance with the Commission's recommendations for the closure of acute care beds and the provision of additional nursing home beds. The study must be conducted on a regional and a facility basis. It should take into account the factors noted, particularly the impact of expanding non-institutional services and home therapies, the increasing number of services which can be provided on an out-patient basis, advances in technology, and changing disease entities/epidemiological trends. Consequently past utilization trends should be only one factor to predict future requirements, i.e., the future is not what it used to be.

With respect to the nursing home/chronic care beds, the study should include an assessment of needs by region and the determination of priorities to meet these needs in line with the fiscal capacity of the Province.

Proposals for the study should include at least the following information:

- an outline of your understanding of the work requested, the approach to be followed, and the nature and content of the reports that will be provided;
- timing and man-day considerations;
- a statement of your firm's experience on similar projects during the past five years;
- the resumés of professional staff who will be assigned to the project as well as an indication of the proposed project manager, and an estimate of the man-days per individual to complete the study;
- detailed schedule of fees and expenses to carry out the study with an outline of the billing procedures of your firm;
- other factors you deem appropriate to the study and your proposal.

The closing date for receipt of the proposals is May 29, 1985, and these should be addressed to:

Mr. Donald R. Keats
Assistant Deputy Minister
Department of Health
P.O. Box 4750
Main Floor, Confederation Building
St. John's, Newfoundland A1C 5T7

In the meantime, please feel free to contact me at (709)576-3127 if you have any questions with respect to the study or require further information.

Yours sincerely,

Don K.

DONALD R. KEATS
Assistant Deputy Minister

DRK:jel

Newfoundland Bed Study - 8514

Respondent Information

1. Name of person answering questionnaire ______________________
2. District ____
3. Office location: Town ____________________________________
4. Population of area served ____________________ (approximate)
5. Size of area served ___________________________________ kms

   (farthest towns from your office)

(Continue with I - Health Care Needs of "At Risk" Community Residents)

Newfoundland Bed Study - 8514

Province of Newfoundland
Public Health/V.O.N. Survey

I Health Care Needs of "At Risk" Community Residents

1. Of those people known to you in your area, please estimate the following numbers:

	Under 65	Over 65	Code
a) need total assistance with personal care (e.g. feed, bath, transfer, dressing, toileting, etc.) on an ongoing basis			
b) need some professional assistance with personal care daily on an ongoing basis but do not need "total" care			
c) need nursing care at home more than 1 time/wk (e.g. dressings, medication, personal care) on an ongoing basis but not on a daily basis			

d) Of those identified in (A) through (C) how many are:

	(A)	(B)	(C)	Total
- living alone				
- living with family members				
- living with elderly or frail spouse				
- living in a personal boarding arrangement (not agency sponsored)				

2. Please give the following information about the primary health conditions of people identified in section 1 as having health care needs. Identify approximate numbers in each category.

_____ Alzheimer's Disease

_____ Mental confusion, requires supervision

_____ Aggressive behaviour

_____ Diabetes

_____ Hypertension

_____ Cancer

_____ Effects of Stroke

_____ Arthritis

_____ Fractures, broken bones

_____ Heart Disease

_____ Respiratory Disease

_____ Loss of limbs

_____ Vision Impairment

_____ Hearing Impairment

_____ Speech Impairment

_____ Skin Problems (ulcers)

_____ Incontinence

_____ Foot Problems

_____ Mobility Limitations

Of the people identified in 1, how many would have more than 1 of the problems listed?

____

Please note any other outstanding health problems which you consider may lead to a requirement for institutional care and numbers with those problems:

____

____

____

____

____

____

II Service Requirements

1. Of the "At Risk" Community Residents identified in section I, for how many in your opinion, would the needs best be met by each of the following services.

   1. Permanent institutional placement (nursing home or hospital long term care) ______
   2. Permanent boarding home or other supervised housing arrangement ______
   3. Comprehensive home care services (includes nursing, homemaker, physiotherapy, occupational therapy, etc) ______
   4. Day hospital/Day care (assuming adequate transportation ______
   5. Respite care (assuming use of other services also) ______
   6. Mobile diagnostic/treatment clinic ______

   Note that 1 and 2 cannot be used in conjunction with 3 - 6, but 3 - 6 can be used in conjunction with each other.

2. In your opinion, what is the rank order for development of the following services in your area?

   High - 1, Low - 5

   1. Nursing home ______
   2. Boarding home or other supervised housing ______
   3. Comprehensive home care services ______
   4. Day care/day hospital (with transportation) ______
   5. Respite care ______
   6. Mobile diagnostic/treatment clinic ______

III Local Services Available

1. Are the following available in your area:

   a) Licensed boarding home yes _____ no _____

   b) Unlicensed boarding home yes _____ no _____

   Where located? ____

   Approx No. of residents ________________________________

   c) Group home

   Mentally ill yes _____ no _____
   - where located?

   Developmentally delayed yes _____ no _____
   - where located?

   Physically handicapped yes _____ no _____
   - where located?

   d) Personal boarding arrangements (either sponsored by an agency or personal arrangement) yes _____ no _____

   If yes, approximate number of people so accommodated.

IV Do you think "at risk" people in your area would generally accept residence in a boarding home setting? yes ____ no ____
If no, please explain.

____

____

____

____

____

____

____

____

Newfoundland Bed Study - 8514

This space is offered for any comments you would like to make about long term care services in general; the attitudes or cultural patterns which exist in your area that might affect utilization of services, the problems with services already in place, etc.

Again, thank you for taking time to complete this survey.

Newfoundland Bed Study - 8514

Glossary

Community residents are people residing in the communities you serve and who are not living in an institution (hospital, nursing home, licensed boarding home) on a permanent basis. Residents temporarily hospitalized should be included.

"At Risk Community Residents" are people of any age whose long term diseases or disabilities lead to a requirement for care and support from health and social services.

"Total assistance with personal care" means that the person is bed or chair fast and is unable to carry out normal daily activities (i.e. toileting, grooming, feeding, dressing, etc) without assistance from a caregiver.

"Some assistance with personal care" means the person requires assistance in one or two areas of normal daily activities such as toileting, dressing, etc. but is unlikely bed or chair fast.

"Professional nursing care" means care provided by a registered nurse or licensed nursing assistant and includes both direct nursing (e.g. injections, dressings and personal care, e.g. bathing)

"Ongoing basis" means an extended period of time beyond a normal recovery period for an acute illness.

Newfoundland Bed Study - 8514

Respondent Information

1. Name of person answering questionnaire ______________________

2. District ____

3. Office location: Town _______________________________________

4. Population of area served ____________________ (approximate)

5. Size of area served ____________________________________ kms

   (farthest towns from your office)

(Continue with I - Health Care Needs of "At Risk" Community Residents)

Newfoundland Bed Study - 8514

Province of Newfoundland
Department of Social Services
District Offices

I Health Care Needs of "At Risk" Community Residents

1. Of those people known to you in your area, please estimate the following numbers:

	Under 65	Over 65	Code
a) need total assistance with personal care (e.g. feed, bath, transfer, dressing, toileting, etc.) on an ongoing basis			
b) need some professional assistance with personal care daily on an ongoing basis but do not need "total" care			
c) need nursing care at home more than 1 time/wk (e.g. dressings, medication, personal care) on an ongoing basis but not on a daily basis			

d) Of those identified in (A) through (C) how many are:

	(A)	(B)	(C)	Total
- living alone				
- living with family members				
- living with elderly or frail spouse				
- living in a personal boarding arrangement (not agency sponsored)				

Newfoundland Bed Study - 8514

2. Please give the following information about the primary health conditions of people identified in section 1 as having health care needs. Identify approximate numbers in each category.

_____ Alzheimer's Disease

_____ Mental confusion, requires supervision

_____ Aggressive behaviour

_____ Diabetes

_____ Hypertension

_____ Cancer

_____ Effects of Stroke

_____ Arthritis

_____ Fractures, broken bones

_____ Heart Disease

_____ Respiratory Disease

_____ Loss of limbs

_____ Vision Impairment

_____ Hearing Impairment

_____ Speech Impairment

_____ Skin Problems (ulcers)

_____ Incontinence

_____ Foot Problems

_____ Mobility Limitations

Of the people identified in 1, how many would have more than 1 of the problems listed?

____

Please note any other outstanding health problems which you consider may lead to a requirement for institutional care and numbers with those problems:

____

____

____

____

____

____

Newfoundland Bed Study - 8514

II Service Requirements

1. Of the "At Risk" Community Residents identified in section I, for how many in your opinion, would the needs best be met by each of the following services.

    1. Permanent institutional placement (nursing home or hospital long term care) ______
    2. Permanent boarding home or other supervised housing arrangement ______
    3. Comprehensive home care services (includes nursing, homemaker, physiotherapy, occupational therapy, etc) ______
    4. Day hospital/Day care (assuming adequate transportation ______
    5. Respite care (assuming use of other services also) ______
    6. Mobile diagnostic/treatment clinic ______

    Note that 1 and 2 cannot be used in conjunction with 3 - 6, but 3 - 6 can be used in conjunction with each other.

2. In your opinion, what is the rank order for development of the following services in your area?

    High - 1, Low - 5

    1. Nursing home ______
    2. Boarding home or other supervised housing ______
    3. Comprehensive home care services ______
    4. Day care/day hospital (with transportation) ______
    5. Respite care ______
    6. Mobile diagnostic/treatment clinic ______

Newfoundland Bed Study - 8514

III Local Services Available

1. Are the following available in your area:

   a) Licensed boarding home yes _____ no _____

   b) Unlicensed boarding home yes _____ no _____

      Where located? ______________________________

      Approx No. of residents ______________________________

   c) Group home

      Mentally ill yes _____ no _____
      - where located?

      Developmentally delayed yes _____ no _____
      - where located?

      Physically handicapped yes _____ no _____
      - where located?

   d) Personal boarding arrangements (either sponsored by an agency or personal arrangement) yes _____ no _____

      If yes, approximate number of people so accommodated.

IV Do you think "at risk" people in your area would generally accept residence in a boarding home setting? yes ____ no ____
If no, please explain.

____

____

____

____

____

____

____

____

Newfoundland Bed Study - 8514

This space is offered for any comments you would like to make about long term care services in general; the attitudes or cultural patterns which exist in your area that might affect utilization of services, the problems with services already in place, etc.

Again, thank you for taking time to complete this survey.

Glossary

Community residents are people residing in the communities you serve and who are not living in an institution (hospital, nursing home, licensed boarding home) on a permanent basis. Residents temporarily hospitalized should be included.

"At Risk Community Residents" are people of any age whose long term diseases or disabilities lead to a requirement for care and support from health and social services.

"Total assistance with personal care" means that the person is bed or chair fast and is unable to carry out normal daily activities (i.e. toileting, grooming, feeding, dressing, etc) without assistance from a caregiver.

"Some assistance with personal care" means the person requires assistance in one or two areas of normal daily activities such as toileting, dressing, etc. but is unlikely bed or chair fast.

"Professional nursing care" means care provided by a registered nurse or licensed nursing assistant and includes both direct nursing (e.g. injections, dressings and personal care, e.g. bathing)

"Ongoing basis" means an extended period of time beyond a normal recovery period for an acute illness.

Newfoundland Bed Study - 8514

Questionnaire
Place of Residence - Nursing Homes

Part I - Resident Population

1. Identify the boundaries of what you consider to be your "local" catchment area.

____

____

2. Of the level III residents in your facility, how many are from the local catchment area identified in question 1 and how many are from outside this area?

No. from local area ______________________________

No. from outside local area ________________________

3. If the number from outside the local area exceeds 10% of your resident level III population, list communities from which they came and reasons why they were admitted to your facility (as apposed to a facility in their local area)

____

____

____

____

____

____

____

4. Of the level II residents in your facility, how many are from the local catchment area identified in question 1 and how many are from outside this area?

No. from local area ______________________________

No. from outside local area ________________________

5. If the number of level II residents exceed 10% of your resident level II population, list communities from which they came and reasons why they were admitted to your facility.

6. Of the level I residents in your facility, how many are from the local catchment area identified in question 1 and how many are from outside this area?

No. from local area ______________________________

No. from outside local area ______________________________

7. If the number of level I residents from outside the local area exceeds 10% of the total level I population, list communities from which they came and reasons why they were admitted to your facility.

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8. Please provide a breakdown by age of your resident population as follows:

	No. <65	No. 65-74	No. 75-84	No. 85+
Level III				
Level II				
Level I				

Part II - Waiting List

Please provide the following information on your current waiting list.

1. Total number on waiting list broken down as follows:

a) Level III ____

b) Level II ____

c) Level I ____

2. By level, identify current location of people on waiting list as follows:

	Hosp	Other Nursing Home	Home of Relative Friend	Own Home	Boarding Home	Other (specify)
Level III						
Level II						
Level I						

3. For the ten most urgent cases on your waiting list, please provide the following information:

(1) 1. Place of residence ______________________

2. Current living situation (own home, home of family, hospital, etc.)

____

____

3. Age ______________ Sex ______________

4. Brief summary of reasons for requiring admission to nursing home.

____

____

____

____

5. Date of last contact with patient or relative

____

(2) 1. Place of residence ______________________

2. Current living situation (own home, home of family, hospital, etc.)

____

____

3. Age ______________ Sex ______________

4. Brief summary of reasons for requiring admission to nursing home.

____

____

____

____

5. Date of last contact with patient or relative

____

(3) 1. Place of residence ______________________________

2. Current living situation (own home, home of family, hospital, etc.)

____

____

3. Age __________________ Sex ___________________

4. Brief summary of reasons for requiring admission to nursing home.

____

____

____

____

5. Date of last contact with patient or relative

____

(4) 1. Place of residence ______________________________

2. Current living situation (own home, home of family, hospital, etc.)

____

____

3. Age ________________ Sex ________________

4. Brief summary of reasons for requiring admission to nursing home.

____

____

____

____

5. Date of last contact with patient or relative

____

(5) 1. Place of residence ________________________

2. Current living situation (own home, home of family, hospital, etc.)

____

____

3. Age ________________ Sex ________________

4. Brief summary of reasons for requiring admission to nursing home.

____

____

____

____

5. Date of last contact with patient or relative

____

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(6) 1. Place of residence ______________________________

2. Current living situation (own home, home of family, hospital, etc.)

____

____

3. Age ____________________ Sex ____________________

4. Brief summary of reasons for requiring admission to nursing home.

____

____

____

____

5. Date of last contact with patient or relative

____

(7) 1. Place of residence ______________________________

2. Current living situation (own home, home of family, hospital, etc.)

____

____

3. Age ____________________ Sex ____________________

4. Brief summary of reasons for requiring admission to nursing home.

____

____

____

____

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5. Date of last contact with patient or relative

____

(8) 1. Place of residence ______________________________

2. Current living situation (own home, home of family, hospital, etc.)

____

____

3. Age ______________ Sex ______________

4. Brief summary of reasons for requiring admission to nursing home.

____

____

____

____

5. Date of last contact with patient or relative

____

(9) 1. Place of residence ______________________________

2. Current living situation (own home, home of family, hospital, etc.)

____

____

3. Age ______________ Sex ______________

4. Brief summary of reasons for requiring admission to nursing home.

____

____

____

____

5. Date of last contact with patient or relative

____

(10)1. Place of residence ______________________________________

2. Current living situation (own home, home of family, hospital, etc.)

____

____

3. Age _______________________ Sex ________________________

4. Brief summary of reasons for requiring admission to nursing home.

____

____

____

____

5. Date of last contact with patient or relative

____